White Memorial Medical Center

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JUL 18 2005

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July 13, 2005

Mark B. McClellan, M.D., Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1290-P
P.O. Box 8010
Baltimore, MD, 21244-8010

Dear Dr. McClellan:

Please accept these written comments regarding the Center for Medicare and Medicaid Service's (CMS's) May 25, 2005 Notice of Proposed Final Rule, Refinements to Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) for FY06: Proposed Changes to IRF PPS for FY 2006, Federal Register, Vol. 70, No 100, Pages 30188 – 30327.

White Memorial Medical Center is one of the region's leading not-for-profit teaching hospitals. Keeping the communities east of downtown Los Angeles healthy has been the mission of White Memorial Medical Center ever since the hospital was founded by the Seventh-day Adventist church in 1913. We are a full-service, 350-bed hospital with advanced services that include rehabilitation, open-heart surgery, orthopedic surgery, cancer services and neonatal intensive care. White Memorial Medical Center is well recognized for medical excellence and a mission of compassionate care

White Memorial Medical Center respects, understands and supports the need to evaluate and refine the PPS system so that it continues to meet the needs of the patients, the providers and CMS. We are committed to working together and hope our comments are constructive.

Thank you for the opportunity to submit input and recommendations in the following areas:

1. The change in proposed methodology for calculating a Functional Independence Measure (FIM) Motor score, using a system of weights for individual FIM items, is extremely complicated and places an undue burden on the providers without the necessary software support and documentation. This change will require an enormous retraining effort for staff to accurately calculate the weighted FIM Motor scores and will result in additional costs to the IRFs. The weighted FIM Motor scores have not been field tested to ensure that the assigned weights reflect the expected resource use and differential item difficulty. The RAND Technical Expert Panel (TEP) recommended against using the weighted FIM Motor scores because it had not been thoroughly tested and was not feasible to implement.

   We adamantly oppose this change and request you omit the weighted FIM Motor Score requirement, as recommended by the TEP.

2. The change in scoring of Toilet Transfers, recording a "2" for patients who are not tested or not observed, will discriminate against the more severely impaired spinal cord injury, amputation or neurological patients who are not capable of executing a Toilet Transfer without total assistance

upon admission to the IRF. Subsequently the FIM Motor scores would increase, and providers may be compensated less for these severely impaired patients, while their costs are potentially higher. This will result in restricted access and reduced resources available for these more severely impaired patients.

We strongly oppose this change. Providers would not take the risk to perform this transfer on severely impaired patients, due to patient safety concerns. We ask that scoring for Toilet Transfers, for patients who are not tested or observed, be reinstated as a score of "1."

3. There are major changes in Case Mix Groups (CMGs), definitions, relative weights and target length of stay (LOS). It appears that relative weights for stroke and traumatic brain injury have decreased more than other impairment groups, thereby further restricting access. Target (geometric mean) length of stay averages have dropped by as much as 33% in one year, forcing providers to discharge patients into community settings much earlier than may be safe or medically appropriate. It is difficult to determine the potential impact; however, if re-weighted CMGs and shorter lengths of stays result in lower payment for conditions and do not adequately cover the cost of care, this may further restrict access to IRFs.

   In addition, the data used (FY 02 and 03) by CMS to calibrate proposed changes is not reflective of current practice with full enforcement of the 75% Rule.

   We recommend that major changes, such as these, be phased in over a period of time, assuring access to critically needed care and safe discharges to the community.

4. The proposed lower outlier threshold, ($4,911) will result in more cases potentially qualifying for outlier payments. The increased percentage of outlier cases and payments may unfairly and non-uniformly prompt increased probe audits from the fiscal intermediaries (FIs).

   We recommend that CMS notify FIs to modify their probe and target audit screens to accommodate a higher percentage of outliers.

In closing, we want to reiterate that changing a majority of the factors in the IRF PPS system for FY06, all at the same time, may create uncertainty and potential damaging effects on the rehabilitation industry, further restricting patient access that is already at risk. Please consider phasing in these changes over time, in order to allow the industry and CMS to assess the impact of these changes on access to rehabilitation services.

Sincerely,

John Raffoul
Executive Vice President and CFO

Mislynne Charles, M.D.
Medical Director of Rehabilitation Services

Sherry Foldvary, M.A., CCC-Sp
Director of Rehabilitation Services

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July 13, 2005

ALLINA
Hospitals & Clinics

Mark B. McClellan, M.D., Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1290-P
PO Box 8010
Baltimore, MD 21244-8010

RE: MEDICARE PROGRAM; INPATIENT REHABILITATION FACILITY PROSPECTIVE PAYMENT SYSTEM FOR FY 2006, Federal Register, Vol. 70, No. 100, Wednesday, May 25, 2005.

Dear Dr. McClellan:

On behalf of Allina Hospitals and Clinics, I appreciate the opportunity to comment on the proposed rule concerning the Inpatient Rehabilitation Facility Prospective Payment System. Allina Hospitals & Clinics is a family of hospitals, clinics and care services that believes the most valuable asset people can have is their good health. We provide a continuum of care, from disease prevention programs, to technically advanced inpatient and outpatient care, to medical transportation, pharmacy and hospice services. Allina serves communities around Minnesota and in western Wisconsin.

Abbott Northwestern Hospital, our largest hospital, located in Minneapolis, MN is recognized as one of the best hospitals in the country, as attested by U.S. News and World Report Best Hospitals in America. The Sister Kenny Rehabilitation Institute (SKRI) is a center of excellence at Abbott Northwestern. Sister Elizabeth Kenny established SKRI in 1942 in response to the polio epidemic. Her pioneering principles of muscle rehabilitation became the foundation of modern physical therapy. SKRI has 55 inpatient beds (at two sites) where acute, inpatient rehabilitation services are provided.

Thank you for this comprehensive rule. Your efforts to support providers and beneficiaries with this payment structure are recognized. We have reviewed and analyzed the impact of the proposed rule. First of all we commend CMS for its commitment to align payments to IRF's as closely as possible with the actual costs of treating patient. Our specific feedback on the proposed changes are noted below.

Proposed Refinements to the Patient Classification System

We support the proposed change that would move dialysis to a Tier One designation in recognition of its clearly higher costs.

However, we are concerned about the proposed changes to the CMGs and relative weights. CMS contracted with RAND to look at data from 2002 and 2003. As a result of their analysis, CMS is proposing the use of the weighted motor score index that increases the explanation of variance within each RIC by 9.5 percent, on average. You are also proposing to eliminate the use of the tub transfer score in determination of a patient's CMG.

Our concern with these proposed changes is that not enough review has been given by experts who have developed and researched the Functional Independence Measurement (FIM) items, of which the motor items are a part. The Proposed Rule mentions that a Technical Expert Panel (TEP) was convened to look at these proposed changes. Given the breadth of the proposed changes to determine the CMGs, and in the absence of any knowledge of who specifically made up the TEP and what specific input they gave, it is our advice that changes to the CMGs should be deferred until both more data can be included (such as use of 2004 data) and an open forum of recognized experts in the field of FIM can be convened to discuss and debate the proposed changes, especially when such changes result in inconsistencies.

If tub transfer scores, for example, offer no predictive value in determination of patient costs, then it would be logical that this item should be removed from the Inpatient Rehabilitation Facility – Patient Assessment Instrument (IFR-PAI) as an unnecessary expense to document and collect. This inconsistency should be resolved before any changes are implemented.

Another inconsistency can be found in Table 6 – Proposed Relative Weights for Case-Mix Groups (CMGs), p. 30213. The proposed relative weights have been changed to adjust payment based on RAND's analysis. The general schema is that Tier None has no relevant co-morbidities that should increase cost, and thus the relative weight within that CMG is the lowest. Tier 1 has the highest relative weight to compensate for the most expensive co-morbidities associated with it; Tier 2 less than Tier 1, and Tier 3 less than Tier 2. However, the accompanying Average Length of Stay for the Tiers does not follow this logical progression. For example, CMG 0103, the Length of Stay (LOS) given for Tier 2 is 20 days, whereas for Tier 1 it is 13 days. With LOS used as a proxy for costs, this is clearly an inconsistency – Tier 1, with the highest costs associated with it, should have the highest LOS. A quick look through Table 6 Average Length of Stay reveals a number of such inconsistencies, including where Tier None has a higher average LOS than Tier 1 (for example, CMG 0109).

It may be that there is a rational explanation for these inconsistencies, but none has been given. This leads one to wonder if the Proposed Relative Weights are not based as soundly on the data as they should be. Before this proposed rule is adopted, this apparent conceptual discrepancy should be explained and resolved.

Negative Financial Impact of the changes to the CMGs and the Proposed Relative Weights

According to the Proposed Rule, "the purpose of the CMG and tier changes is to ensure that the existing resources already in the IRF PPS are distributed better among IRFs according to relative costliness of the types of patients they treat." (Page 30219) CMS further states that it is attempting to ensure that the total estimated aggregate payments to IRFs do not change.

This is an empirical question that should be resolved in advance of implementation. Sister Kenny, cannot, of course, determine how the Proposed Rule will impact other IRFs in order to measure the aggregate effect. However, we have looked at our Medicare patients discharged to the community from one of our sites between January 2004 and March 2005, to determine the impact of the proposed changes in CMGs and relative weights. The impact is overall negative, with a net decrease in payments by 2.54% (using the proposed standard payment conversion factor, with proposed facility adjustments). Aside from this, the resulting decrease in payments is troubling because it is not uniform among RICs, nor it is uniform among CMGs within RICs. For example, payments would increase to current CMGs 0102 and 0113, but would decrease to almost all the other Stroke CMGs. Our non-traumatic spinal cord CMGs would have the greatest decrease in payments, followed by non-traumatic brain injury CMGs (except for 0301). For traumatic brain injury CMGs, 0203 payments would decrease and others would stay almost the same. Surprisingly, payments for most replacement of lower extremity CMGs would increase.

Because of the lack of uniformity in how payments would be impacted at just one IRF, we advise CMS to defer implementation of this Proposed Rule until the full impact on all IRFs can be further analyzed in light of more data. The resulting change in payments may be more than just a better redistribution among IRFs. Instead, patients' access to needed inpatient rehabilitation may be adversely impacted simply due to the CMG they may fall into (not even considering the 75% Rule). The concern is that the net changes in payments among the CMGs do not reflect a closer approximation of costs within and among RICs, and will instead drive what patients are admitted to IRFs in spite of their rehabilitation needs.

Proposed FY 2006 Federal Prospective Payment Rates

Allina strongly supports CMS's proposal to update the low-income patient (LIP) adjustment to account for differences in costs among IRFs associated with differences in the proportion of low-income patients they treat. We agree that this reflects variations in necessary costs of treatment among rehabilitation facilities. The update to this factor will more accurately reflect the cost of providing services to an increased percentage of low-income patients.

Additionally, Allina supports the adoption of the new CBSA-based labor market area definitions with the 2006 IRF PPS rule, without a transition period. Moving all facilities immediately to the CBSA-based labor markets will be administratively simpler than having a transition period for some or all facilities. We thank CMS for the analysis of various implementation approaches to provide the smoothest transition from MSAs to CBSAs, and agree with the implementation approach detailed in the proposed rule.

Provisions of the Proposed Regulations

There are a few revisions to the regulations we request CMS review to remove potential discrepancies and to ensure consistency within the regulations. These updates are listed below.

§412.25
In the update to the IPF PPS final rule, a reference to rehabilitation units was removed from §412.25(a), and was not replaced elsewhere in §412.25.

- 42 CFR 412.25(a), revision 2004:
  "Basis for exclusion. In order to be excluded from the prospective payment systems specified in §412.1(a)(1), a psychiatric or rehabilitation unit must meet the following requirements"
- 42 CFR 412.25(a), as modified in 69 FR 66976:
  "Basis for exclusion. In order to be excluded from the prospective payment systems as specified in § 412.1(a)(1) and to be paid under the prospective payment system as specified in 412.1(a)(2), a psychiatric unit must meet the following requirements."

We request that CMS address the removal of the rehabilitation unit from the requirements in §412.25(a), either by reinserting the phrase "or rehabilitation" in the text, or by creating a new section in §412.25 specifically for rehabilitation hospitals.

Discrepancies Regarding Change in Status of Excluded Units

There are various locations within the regulations governing excluded hospitals and hospital units that discuss requirements for change in excluded status. This includes §412.25(c) and §412.22(d). We request clarification to ensure that these regulations are in synch.

- §412.22 includes general rules for excluded hospitals and hospital units. §412.22(d) states that hospitals may only change status of either excluded or not excluded at the start of a cost reporting period.
- §412.25 lists the common requirements for excluded hospital units. §412.25(c)(2) permits the status of a hospital unit to be changed from excluded to not excluded at any time during the cost reporting period if the hospital notifies the appropriate parties within the appropriate timeframe.

Allina would like CMS to address whether section §412.22(d) applies only to excluded hospitals, or to both excluded hospitals and excluded units. We also request that the CMS Internet Only Manual (100-4, Chapter 13, Section 3120) be updated with this clarifying information.

Errata

There are two (or more) errors in Table 3 of the Addendum - Inpatient Rehabilitation Facilities with Corresponding State and County Location; Current Labor Market Area Designation; and Proposed New CBSA-based Labor Market Area Designation: the Provider Numbers of Sister Kenny Rehabilitation Institute at Abbott Northwestern Hospital is 24T057, and at United Hospital it is 24T038 (we are unsure if the accompanying SSA and MSA codes also need to be corrected).

Thank you for your consideration of our comments on the proposed rule. If you have any questions about our comments please feel free to contact me at (612) 775-9744. We look forward to your response in the final rule.

Sincerely,

Nancy G Payne

Nancy G. Payne, RN
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JUL 18 2005

SOUTHERN KENTUCKY REHABILITATION HOSPITAL

July12, 2005

Mark McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

Attention: CMS-1290-P

Re: Proposed Revisions to the IRF PPS Geographic Classification

Dear Administrator McClellan:

On behalf of the Southern Kentucky Rehabilitation Hospital, I am writing to express concern with section (III)(B)(2) of the proposed update to the Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2006. *See* 70 Fed. Reg. 30188, 30234 (May 25, 2005). In that section, you propose new "labor market area" definitions that will, among other things, reclassify certain areas from rural to urban. These seemingly innocent administrative changes will cause significant harm to the Southern Kentucky Rehabilitation Hospital and the community it serves. Despite past insistence from Congress that geographic reclassifications not harm hospitals that have come to rely on a given level of payment, these proposed changes are to be made without the creation of a "rural floor" or any other system of compensation for those hospitals that will be harmed by the reclassification. We urge you to reconsider.

I. Background

The Southern Kentucky Rehabilitation Hospital is located in Bowling Green, Kentucky but serves a patient population encompassing much of rural southern Kentucky and northern Tennessee. We are committed to superior patient care, medical excellence, and responsive case management. Our 60-bed hospital offers a comprehensive range of inpatient programs to help patients overcome or adapt to the effects of physical and neurological illness or injury.

The proposed geographic reclassification will interfere with this mission and will severely limit our ability to serve both the Medicare population and the community at large. For instance, we project that for a patient placed in Case Mix Group ("CMG") 0101 (Stroke) with no comorbidities, our facility will be reimbursed $5,775.06 if Bowling Green is deemed a rural area.[1] However, if the proposed rule is enacted as written and we are deemed an urban facility, we will be reimbursed only $4,808.33 for treating the same patient. Similarly, as a rural facility we would receive $9,761.77 for a patient with no comorbidities in CMG 1001 (Amputation, Lower Extremity) but only $8,127.69 if we are reclassified. In total, we estimate that our annual revenue will decrease by two million dollars under the proposed rule despite costs remaining the same. These differences are significant and will have a direct, serious, and negative impact on our ability to provide rehabilitative services to the community.

[1] These calculations include all appropriate adjustments (DSH, wage, rural, etc.) to the proposed base rate.

II. The Proposed Rule

Under the Inpatient Rehabilitation Facility Prospective Payment System ("IRF PPS"), CMS uses a hospital wage index to adjust Medicare payment rates for regional variations in labor costs. This index is determined by examining wages in each hospital's assigned labor market and is influenced by a hospital's designation as either rural or urban. Labor markets, in turn, are defined either by Metropolitan Statistical Areas ("MSAs") or by state level aggregates of rural areas not placed in an MSA.

In June 2003, the White House Office of Management and Budget ("OMB") announced new Core Based Statistical Areas ("CBSAs") and recognized 49 new MSAs. CBSAs are comprised of MSAs and newly created Micropolitan Statistical Areas (CMS has chosen not to adopt this latter classification). Although OMB cautions that the new CBSAs "are not intended to serve as a general-purpose geographic framework for nonstatistical activities" and warns that MSAs may not be appropriate for "program funding formula" because they "do not equate to an urban-rural classification," CMS proposes to use the new definitions to define labor markets and thus payment levels under the IRF PPS. *See* OMB Bulletin No. 04-03 *available at* http://www.whitehouse.gov/omb/bulletins/fy04/b04-03.html; 70 Fed. Reg. at 30234-30235.

III. Rural Versus Urban Designation

The proposed rule justifies the decision to adopt OMB's CBSAs by noting that other Medicare prospective payment systems use the same definitions and that MSAs represent a "reasonable and appropriate proxy" for labor market areas. The designations "reflect the characteristics of unified labor market areas." 70 Fed. Reg. at 30235. We disagree with this analysis. First, we note that justifying the new definitions by relying on the procedures of other prospective payment system is circular reasoning. While other systems may incorporate MSAs into their regulations, this does not, by itself, imply that MSAs are suited for this purpose. The other systems are also ignoring OMB's cautionary statements. Furthermore, while it may be true in the general sense that MSAs reflect labor markets, CMS has not addressed OMB's warning that "many counties included in [Metropolitan Statistical Areas] ... contain both urban and rural territory and populations." OMB Bulletin No. 04-03. Indeed, we believe the very situation OMB envisioned – a failure to appreciate the rural nature of a region now called a Metropolitan Statistical Area – is the case for Southern Kentucky Rehabilitation Hospital.

Although the city of Bowling Green has been reclassified by OMB as an MSA, our hospital serves a fundamentally rural population and should be reimbursed accordingly. Our patients and our employees hail from many counties in the southern Kentucky region. With the exception of the portion of Warren County that encompasses Bowling Green, this area is quite rural. Moreover, even Bowling Green is a small city that just barely satisfies the 50,000 person threshold established by OMB to be designated an MSA. If CMS is to adopt a classification system that OMB cautions "may not accurately address issues or problems faced by local populations, institutions, or government units" 65 Fed. Reg. 82228, 82229 (Dec. 27, 2000), it must consider those hospitals and those communities that "fall through the cracks" – those hospitals designated urban for administrative and statistical purposes but which are, in fact, rural.[2]

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[2] The proposed rule notes that many of the formerly rural hospitals redesignated as urban institutions by the OMB changes will benefit from the change. 70 Fed. Reg. at 30239. This is cold comfort to hospitals, such as ours, that will be harmed by the change.

IV. The Importance of a Rural Floor

Congress has recognized the inexactness of the MSA system and the potentially devastating effects of a change in a hospital's geographic status. As the proposed rule notes, Section 4410 of the Balanced Budget Act of 1997 (Pub. L. No. 105-33) requires CMS to create a "rural floor" for hospitals reimbursed under the prospective payment system. *See* 70 Fed. Reg at 30234. "The area wage index applicable to hospitals located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas of the State." 42 U.S.C. § 1395ww note. This rural floor prevents hospitals from suddenly losing funds simply because a non-healthcare agency, solely concerned with statistical recordkeeping, reclassified certain rural counties as urban.[3]

Nevertheless, without any explanation other than consistency with past IRF policy, CMS has chosen to ignore this law. 70 Fed. Reg at 30234 and 30240. The reference to past IRF policy is particularly unsatisfying since this is the first time the IRF PPS geographic classification system has been changed since the system was first implemented in 2001. In other words, this is the first time an inpatient rehabilitation facility that has structured its operations and its budget according to its rural designation faces the prospect of reclassification into an urban MSA and would need to invoke the rural floor.

Throughout section (III)(B)(2) of the proposed rule, CMS compares the IRF PPS to the Inpatient Prospective Payment System ("IPPS"). The IPPS, CMS notes, has already adopted OMB's revised MSAs. Moreover, the IRF PPS wage index is calculated by using the acute care IPPS wage index data; the IRF industry has "understood that the same labor market areas in use under the IPPS ... would be used under the IRF PPS," and the proposed IRF PPS definitions are "consistent with the IPPS approach." 70 Fed. Reg. at 30234 – 30235. CMS even notes that a more detailed discussion of the conceptual basis for OMB's revisions can be found in the IPPS rule. *Id.* The IPPS, of course, has a rural floor. If the IPPS model is so close to the IRF PPS that it can repeatedly be used to justify changes to the IRF PPS, we feel that it is only reasonable for CMS to provide hospitals with the same safeguards found in the IPPS. A rural floor is an integral part of the IPPS. It guarantees fairness and compensates for the limitations of OMB's Metropolitan Statistical Areas. The IRF PPS should be treated no differently.

IV. Conclusion

We urge CMS to recognize the fundamentally rural nature of our hospital's community and allow the Southern Kentucky Rehabilitation Hospital to retain its rural designation. The proposed rule, as written, will have a devastating effect on our ability to serve the rural communities of southern Kentucky and northern Tennessee. We also ask CMS to follow section 4410 of the Balanced Budget Act of 1997 and the IPPS model – establish a rural floor that will both cushion the jarring real world effects of this administrative change and address the inadequacy of using OMB's Metropolitan Statistical Areas as a proxy for an urban/rural analysis of America's communities.

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[3] There are other instances where Congress has legislated that a hospital should not lose money because of an administrative change affecting geographic designations. For example, if a decision from the Medicare Geographic Classifications Review Board to reclassify a rural hospital reduces the wage index for that rural area, CMS must calculate the wage index as if the reclassified hospital had not been moved. *See* 42 U.S.C. § 1395ww(d)(8)(C)(ii).

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The Southern Kentucky Rehabilitation Hospital

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HEALTHSOUTH®

July 18, 2005

JUL 18 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW.
Washington, DC 20201

Re: Medicare Program; Proposed Changes to the Inpatient Rehabilitation Facility Prospective Payment System "IRF PPS" for FY 2006

Dear Dr. McClellan:

HealthSouth Corporation is one of the nation's leading providers of inpatient rehabilitative healthcare services, operating 95 inpatient rehabilitation facilities (IRFs) in 28 states. We are pleased to present the following comments on the May 25, 2005 notice of proposed rulemaking ("NPRM") relating to "*Proposed Changes to the Inpatient Rehabilitation Facility Prospective Payment System for FY 2006*".

SUMMARY AND RECOMMENDATIONS

For the reasons described more fully below, we recommend that the Centers for Medicare and Medicaid Services (CMS) not proceed with the proposed changes to payment formulas under the IRF PPS. We make this recommendation based on a several serious defects with the FY 2002 and 2003 cost report and claims data used by CMS and the RAND Corporation to support the proposed changes. This data omits an estimated $110-115 million of home office and depreciation costs for HealthSouth's IRFs during each of these years and also fails to account for significant shifts in average IRF case mix and per case costs resulting from recent changes to the 75% Rule.

1. Omission of HealthSouth Cost Report Data. As part of a December 2004 administrative settlement with CMS, HealthSouth agreed not to seek reimbursement for home office or depreciation costs for 2002 or 2003 or to include such costs in facility cost reports without the approval of CMS. The settlement included no finding that the full amount of these costs were not allowable and consistent with the parties understanding, contained a specific provision that allowed CMS to consider the settlement (and underlying data) in

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future rate settings.[1] Because the CMS/RAND analysis relied directly on FY 2002 and 2003 cost reports to formulate the payment changes proposed in the NPRM, the omission HealthSouth costs which would otherwise be allowable under Medicare cost accounting rules from this baseline data will materially distort the accuracy of future payments not only to HealthSouth but to virtually all other IRFs. The parties to the settlement agreement specifically contemplated that costs for covered cost reporting periods, including unreported costs in 2002 and 2003, would be utilized, if necessary, to set future reimbursement rates. The Company has always been amenable to preparing informational cost reporting materials for such purposes. Until the Company reviewed the data in the NPRM, however, it was not aware that FY 2002 and 2003 cost report data would be utilized for future rate setting.

2. Effects of the 75% Rule. The implementation of changes to the 75% Rule in July 2004 has had a significant effect on IRF case volume, case mix, and unit costs. Based on data from over 600 IRFs reporting discharge data to the Uniform Data System for Medical Rehabilitation (UDS_{MR})[2] from calendar 2002 through the first quarter of 2005, these changes are expected to contribute to a significant decline in IRF admissions during the first full year of enforcement at a 50% compliance level – 8.6% from FY 2004 and 8.3% from FY 2003 levels. The effects of this reduction on case mix (a trend toward higher acuity and therefore more expensive cases) and unit costs (higher fixed costs per case as average facility census declines) have not been adequately analyzed by CMS nor addressed in the proposed Rule. The result is likely to be a systematic underestimate of future IRF costs. If the compliance threshold is increased according to the schedule currently outlined in the new 75% Rule, these distortions will become more pronounced over time.

3. Payment System Design. One of the underlying tenets of a prospective payment system is that providers receive reimbursement based on average costs for all providers for a given condition or diagnosis. However, some of the changes to IRF PPS payment rates proposed by the NPRM appear to be based on observed difference in relative costs per case among different classes of providers. Some of these perceived differences in cost are likely attributable to the omission of HealthSouth cost report data described above. Others maybe attributable to separate factors. Although we recognize the need for PPS payments to accommodate costs incurred IRF providers in all settings, we urge CMS to ensure that payment incentives remain in place for all providers to aggressively pursue more efficient methods of delivering quality health care.

Until CMS is able to eliminate the combined distortions caused by these factors from the rate setting process, no significant changes should be made to the current IRF PPS. The IRF PPS has

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[1] As was done by CMS in 2002 in the development of a new prospective payment system for Long Term Care Hospitals. See discussion, page 8, *infra*.

[2] UDS_{MR} is associated with the University of Buffalo and provides inpatient rehabilitation facilities with outcomes reporting services and national benchmarks. It is world's largest non-government repository of rehabilitation outcomes and IRF-PAI data.[2]

been fully implemented for less than 2 years. We see no reason for haste in revising future payment rates using cost and claims data known to be unrepresentative of current and future periods or that exclude a material portion of overall costs. We therefore recommend that CMS proceed with an appropriate market basket adjustment to the IRF PPS without other material changes to program rate formulas.

SPECIFIC COMMENTS ON THE PROPOSED RULE

I. Proposed IRF Prospective Payment System Design and Data Elements

A. Failure to Account for Effects Caused by Implementation of Changes to the 75% Rule Criteria

This NPRM is the first refinement of the inpatient rehabilitation facility prospective payment system (IRF PPS) since the new payment system was implemented for cost reporting periods ending on or after January 1, 2002. In the development of the FY 2006 proposed rule, CMS and the RAND Corporation, who conducted the research work on behalf of CMS, utilized cost report and claims data from the 2002 and 2003 fiscal years. Subsequent to the initial PPS transition years, CMS implemented substantial changes to the criteria used for classification of inpatient rehabilitation facilities. These changes to the 75% Rule became effective during 2004 for the majority of IRFs. The stated purpose of these changes was to ensure that IRFs are focusing care on the types of patients and conditions that typically require an inpatient level of rehabilitation care. CMS acknowledges in the NPRM that changes to case mix resulting from the new 75% Rule could affect the validity of analyses based on time periods preceding its implementation.[3] We share this concern. Until the effects of the new 75% Rule have been further quantified, there is no basis to conclude that the adjustments proposed by CMS will adequately address the substantial changes in discharge patterns, case mix and unit costs caused by the new 75% Rule.

Analysis of our own claims data, as well as data compiled by independent sources, indicate the new 75% Rule is having a substantially greater effect on IRF discharges than originally projected by CMS.[4] A noticeable decline in discharges for the first half of FY 2005 for more than 600 IRFs reporting discharge data to UDS_{MR} suggests that as many as 40,000 fewer patients will be admitted to IRFs during the year. This substantially exceeds an initial CMS estimate of approximately 2,000 fewer discharges, based on savings assumptions included in the Impact Analysis accompanying the new 75% Rule.[5] This represents a decline

[3] "IRFs' current cost structures may be changing as they strive to comply with other recent Medicare policy changes, such as the criteria for IRF classification commonly known as the "75 percent rule." May 25, 2005 Federal Register, Page 30222

[4] See Appendix A

[5] Federal Register / Volume 69 No. 89 / May 7, 2004

of approximately 8.6% of total Medicare IRF discharges from FY 2004. It also reflects a decline of approximately 8.3% from FY 2003 levels.

The new 75% Rule is also having an effect on case mix and costs per case. The mix of qualifying orthopedic cases is declining as a result of the new criteria for arthritis conditions and joint replacement. UDS_{MR} data presented to CMS last month by inpatient rehabilitation hospital organizations indicated a decrease in the number of lower extremity joint replacement cases (7.2%), lower extremity amputation cases (7.7%), osteoarthritis cases (63.1%), pulmonary cases (35.3%) and cardiac cases (22.5%) when comparing the 1st quarter of 2005 to the 1st quarter of 2002. The new 75% Rule is also reducing admissions of miscellaneous conditions. The remaining cases admitted for treatment tend to have a higher acuity level and therefore higher average costs. Because the FY 2002-2003 base period used to calibrate the proposed refinements to PPS rates reflect a blend of lower cost cases, it is not representative of current IRF case mix. As the compliance thresholds increase under the new 75% Rule, the magnitude of this disparity will also increase. Recalibration of future IRF PPS payments based on this data will likely yield inaccurate CMG weights and significant payment shortfalls in a post-75% Rule environment.

The new 75% Rule will also have an escalating effect on costs per case. With the average daily census for many IRFs declining as a result of fewer qualifying cases under the rule, operational cost structures are being disrupted. Facilities are being challenged to reduce variable costs to match new, lower census levels. At the same time, fixed costs are being allocated across a reduced number of cases. This will be a particular issue for freestanding facilities which may have few options to shift unused beds to other uses. An IRF with fixed costs at 30% of total cost per case could experience an increase in its cost per case of approximately 3.3% to 5.3% assuming a decline in admissions of 10% to 15%. Again, as higher compliance levels under the new 75% Rule cause further reductions in average IRF census, the resulting increases in fixed unit costs will exacerbate future payment shortfalls.

Recommendation

We do not believe that CMS has enough data to model the effect of the changes to the new 75% Rule on IRF case volumes and case mix to support a refinement to PPS payment rates at this time. We therefore recommend that CMS delay the proposed refinements until case data for periods following full implementation of the new 75% Rule become available. In the interim, we recommend that CMS continue to monitor case mix trends associated with the new 75% Rule as the compliance thresholds provided in the rule escalate.

B. Missing HealthSouth Cost Report Data

In December 2004, HealthSouth entered into a global settlement with the U.S. Department of Justice, the Office of Inspector General of the Department of Health and Human Services (OIG), and the Centers for Medicare & Medicaid Services (CMS) to resolve outstanding issues associated with various prior Medicare billing and cost reporting practices. HealthSouth elected not to claim home office costs and a very large portion of depreciation

costs on facility cost reports for 2002 and 2003 due to a concern that some of the costs would not be allowable under Medicare cost accounting rules. At the time, the Company could not determine which costs might be affected. We therefore elected a conservative course and excluded all of the costs – even though we had every reason to believe that the bulk of the costs would have been allowed. Because reimbursement for IRF care in FY 2002 was no longer cost-based, there was no compelling need for the Company to undertake a thorough restatement of these costs for Medicare cost report purposes. The treatment of these costs was subsequently resolved by the parties in a final administrative settlement agreement between CMS and HealthSouth in December 2004. The agreement contained no finding on how much of the excluded costs may have been allowable. Instead, HealthSouth agreed not to seek reimbursement of any excluded home office or deprecation costs for 2002 and 2003 and not to include such costs in facility cost reports without the approval of CMS. The settlement agreement specifically retained authority for CMS to review and adjust data in HealthSouth cost reports for computing future reimbursement rates.[6]

The exclusion of these costs from 2002 and 2003 cost reports now becomes an issue for all IRF providers because CMS is basing the proposed refinements to PPS rates on a RAND Corporation analysis of IRF cost reports for those years. We reach this conclusion based on a review of the proposed rule and the supporting RAND Technical Report. Following are several examples where we believe the regression model developed by RAND may be reaching inappropriate conclusions based on the missing cost data.

1. Using the Inpatient Rehabilitation Facility Rate Setting File located on the CMS website, we identified the HealthSouth facilities using the provider numbers provided by CMS. Based on our analysis of this file, HealthSouth facilities had an overall average case-mix index that was higher than all facilities combined. However, the average cost per discharge for HealthSouth facilities was significantly less than all facilities combined. Even though HealthSouth is committed to furnishing services in a cost-efficient manner and believes that our facilities are among the most efficient providers in the IRF field, the magnitude of this variance could only be attributable to the exclusion of the Company's home office and depreciation costs.

2. The proposed refinements are based in part on case-level and facility-level analyses. RAND estimated the cost for each case "by applying a departmental cost-to-charge

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[6] Paragraphs 6 and 7 of the December 2004 Administrative settlement agreement provide:

6. Notwithstanding this or any other provision of the Agreement, HHS reserves the right to reopen the HealthSouth Covered Cost Reports in order to comply with any act of Congress requiring HHS to rely on settled cost reports for such year(s) as a basis for adjusting Federal payment rates to Medicare providers. HHS will not use any such reopening either to pay any additional amounts to or seek further payments from HealthSouth and any HealthSouth Providers for the reopened cost reporting period(s).

7. Notwithstanding this or any other provision of the Agreement, HHS retains the right to review and adjust any data and statistics set forth in any HealthSouth Covered Cost Reports for computing future reimbursement amounts that are dependent on the settlement of prior cost reports.

ratio from the cost report to the patient's charge in the department as reported in the claims file (plus) the average per diem costs for "room and board" multiplied by the patient's length of stay."[7] Furthermore, CMS states "We obtained cost-to-charge ratios for ancillary services and per diem costs for routine services from the most recent available cost report data.... For ancillary services, we calculate both operating and capital costs by converting charges from Medicare claims into costs using facility-specific, cost-center specific cost-to-charge rations obtained from cost reports.... For routine services, per diem operating and capital costs are used to develop the relative weights.... Per diem costs are obtained from each facility's Medicare cost report data."[8] With the use of facility specific departmental cost to charge ratios and per diem costs, from the latest available cost reports, in calculating an estimated cost per claim, this would indicate that home office and depreciation costs were excluded.

3. According to RAND, the regression analyses included in its Phase I report supporting the initial design and implementation of the IRF PPS, "indicates that proprietary facilities are more costly than not for profit or governmental institutions."[9] However, our analysis of the Inpatient Rehabilitation Rate Setting File shows that proprietary facilities have a significantly lower cost than not for profit or governmental facilities using FY 2002 and 2003 data. Since HealthSouth facilities make up at least 25% of all proprietary facilities, it is likely that this shift is a direct result of that the exclusion of HealthSouth home office and depreciation costs from the database.

4. RAND also concluded in its updated research that "freestanding IRFs are less expensive than units ($10,274 versus $11,702); in contrast, freestanding IRFs were more expensive in Phase I."[10] Since HealthSouth has at least 40% of the freestanding facilities, this provides further evidence that HealthSouth home office and depreciation costs have not been included in the updated research. A separate analysis comparing the Medicare cost per admission between rehabilitation hospitals and hospital-based units was performed by the Federation of American Hospitals using the 3/31/2005 HCRIS data (this includes all filed and settled IRF Medicare IRF cost reports.) (see Chart I below). The average cost per admission for both rehabilitation hospitals and hospital-based units were very similar from 1999 to 2001. In 2001, the average cost per admission for a hospital was $10,573 compared to

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[7] Paddock SM, Carter GM, Wynn, BO, and Zhou AJ; Possible Refinements to the Facility-Level Payment Adjustments for the Inpatient Rehabilitation Facility Prospective Payment System, RAND Health, page 5.

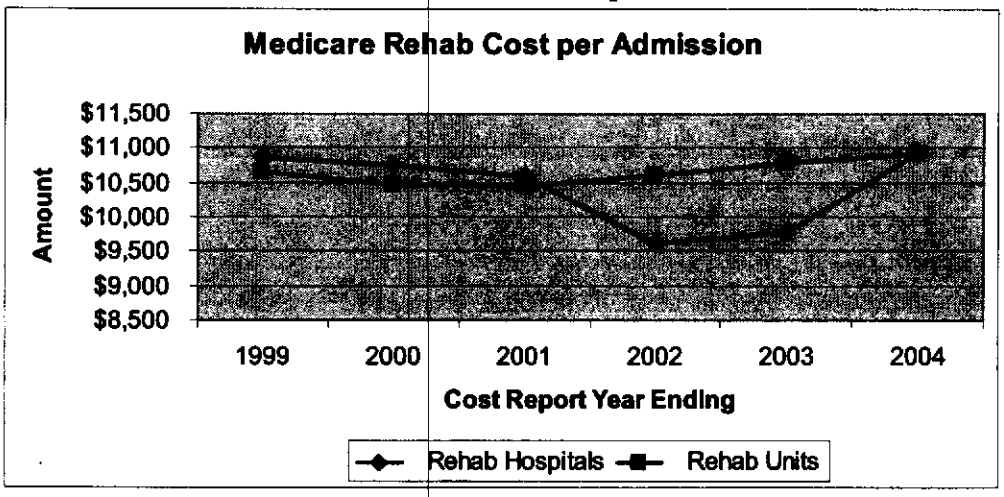
[8] Medicare Program - Inpatient Rehabilitation Facility Prospective Payment System; FY 2006 Proposed Rule, May 25, 2005 Federal Register Page 30194

[9] Paddock SM, Carter GM, Wynn, BO, and Zhou AJ; Possible Refinements to the Facility-Level Payment Adjustments for the Inpatient Rehabilitation Facility Prospective Payment System, RAND Health, page 11.

[10] Paddock SM, Carter GM, Wynn, BO, and Zhou AJ; Possible Refinements to the Facility-Level Payment Adjustments for the Inpatient Rehabilitation Facility Prospective Payment System, RAND Health, page 13.

$10,443 for a hospital based rehab unit. In 2002, the average cost per rehabilitation hospitals admission decreased $956 to $9,617 compared to an increase of $158 to $10,601 for hospital-based rehab units. The distortion continued in 2003. In 2004, the average cost per admission for rehabilitation hospital increased $1,339 to $10,916 which is comparable to the $10,911 average cost per admission for hospital-based rehabilitation units providing evidence of the impact of the missing cost.

Chart 1: Medicare Rehab Cost per Admission



We have attempted to calculate the magnitude of the missing cost data using 2004 home office and depreciation cost report data filed by HealthSouth as a proxy for 2002 and 2003 Medicare costs. Using this approach, we estimate that approximately $197M in 2002 and $176M in 2003 in allowable costs were excluded from HealthSouth cost reports. We further estimate that Medicare's share of these excluded expenses was $115 million in 2002 and $111M in 2003.[11] These costs represent approximately 15% of total HealthSouth allowable costs for those years.

Assuming that HealthSouth currently accounts for roughly 20% of the overall IRF claims, approximately 3% of total industry costs may be missing from the regression analysis.[12] More significantly, these costs represent approximately 6.5% of allowable costs for urban hospitals which are proposed to receive significant payment reductions under the new rate structure.

We are very concerned that the proposed shift of payments under the NPRM may be based in large part on the omission of the HealthSouth cost data. This error will also affect a substantial number of non-HealthSouth providers. We believe that the omission of costs of

[11] See Appendix B and C for the supporting analysis of HealthSouth excluded cost.

[12] Calculated by multiplying the 15% understated cost by HealthSouth's 20% share of the IRF discharges.

this magnitude from the CMS/RAND database and accompanying regression analysis are material to the integrity of conclusions drawn from the data and warrant further CMS analysis before proceeding with the proposed rate refinements.[13]

There is a recent precedent for addressing a data integrity issue of a similar magnitude. During the development of the Long Term Acute Care Hospital (LTCH) Prospective Payment System (PPS), CMS had "significant concerns about the integrity of some of the cost report data."[14] CMS specifically pointed to a *qui tam* settlement involving a hospital chain that represented approximately 20% of the LTCHs nationwide. In that instance, CMS adjusted the cost report data filed by the hospital chain to correct for the effects of the settlement."[15] CMS also commented that "in order to avoid the negative impact those providers' data may otherwise have on the integrity of the data, we are basing our proposed standard Federal rate on a factor determined by CMS's Office of the Actuary to adjust the costs reported in those affected FY 1998 and FY 1999 cost reports."[16]

This precedent underscores the need to protect the integrity of the data used to support changes to PPS base rates and to ensure that any refinement is both accurate and fair to all IRF providers. Failure to correct known material defects in the underlying data, as was done in the LTCH final rule, would unfairly affect many IRF facilities, particularly those located in urban areas. CMS should use the precedent established in the LTCH PPS rulemaking to take comparable steps to ensure the integrity of the data and analyses used to refine the IRF PPS.

We understand that the omission of the HealthSouth cost data should not have a bearing directly on the Standard Federal Base Rate.[17] However, many of the other proposed rate and budget neutrality adjustments which result in a redistribution of payments among different classes of IRF providers may be calculated in error. We have addressed below a few of the areas that we believe may be most directly affected by this omission. While this list is not exhaustive, it serves to underscore the need to reexamine every element of the regression analysis to ensure that the omission of the HealthSouth data does not produce inappropriate results.

1. Omission of the cost data for 88 HealthSouth IRFs classified as urban facilities has likely caused urban cost per case calculations to be materially understated. This, in

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[13] We communicated our initial concerns abou the omission of HealthSouth home office and depreciation costs to CMS shortly following the publication of NPRM.

[14] Federal Register /Vol. 67, No. 56 / Friday, March 22, 2002, pg 13469

[15] Federal Register /Vol. 67, No. 169 / Friday, August 30, 2002, pg 56029

[16] Federal Register /Vol. 67, No. 56 / Friday, March 22, 2002, pg 13470

[17] We assume that total IRF expenditures would be calculated in a budget neutral manner after inclusion of the proposed market basket adjustment of 3.1%.

turn suggests that the proposed increase in the Rural Add-On Adjustment from 19.14% to 24.1% may be significantly overstated.

2. The labor-related share has increased from 72.359 percent in FY 2005 to 75.958 in the proposed rule. The proposed rule indicates that CMS used the proposed FY 2002-based RPL market basket costs to determine the proposed labor-related share for the IRF PPS. With the exclusion of non-labor home office and depreciation costs from HealthSouth facility cost reports, the increase in the labor-related share is likely to be overstated. This will affect all rate payment calculations based on the revised labor share calculations.

3. The proposals to change the Low Income Patient (LIP) Adjustment and include a Teaching Adjustment were also based on the results of regression analysis using FY 2002 and 2003 cost report data. The proposed adjustments are based on observed variations in costs per case between IRFs that serve a large percentage of low income patients or maintain medical education programs. To the extent that HealthSouth facilities may be under-represented in either of these classes, the omission of Company costs could distort the relative costs per case used to support the adjustments. These adjustments should be re-evaluated once the missing cost data is incorporated in the regression model.

4. New CMG weights have been calibrated using overall case costs, including home office and depreciation costs. Recognizing that the HealthSouth facilities have a higher overall case mix index than the industry as a whole, recalculation of these weights could yield different results if the missing HealthSouth costs were included. This should result in a material redistribution of the CMG weight and Co-morbidity Tier Adjustments.

5. The proposed changes to the LIP Adjustment, the Rural Add-On Adjustment, and the CMG weight along with the new Teaching Adjustments have been done in a budget neutral manner. The related budget neutrality adjustments will have to be recalculated to reflect any changes to the underlying rate formulas.

The parties to the settlement agreement specifically comtemplated that costs for covered cost reporting periods, including unreported costs in 2002 and 2003, would be utilized, if necessary to set future reimbursement rates. The Company has always been willing to prepare informational cost reporting materials for such purposes. Until the Company reviewed the data in the NPRM, however, it was not aware that FY 2002 and 2003 cost report data would be utilized to propose changes in future reimbursement rates.

Recommendation

With the omission of approximately 3% of total IRF cost data from the CMS/RAND database in FY 2002 and 2003, the regression analysis underlying the proposed PPS refinements must be recalculated. This could be done (1) by using the proxy values derived

from an analysis of FY 2004 HealthSouth cost report data to produce an estimate of HealthSouth home office and depreciation costs for FY 2002-2003 or (2) by eliminating all HealthSouth costs from the analysis. We understand that neither option may provide a level of data integrity that would be acceptable to CMS or to other IRF providers. If so, the most prudent course may be to delay implementation of proposed PPS refinements until additional analysis can be undertaken to develop a more reliable cost baseline.

C. Payment System Design

Prior to the adoption of the IRF PPS, inpatient rehabilitation facilities were reimbursed by the Medicare program on the basis of cost. A stated purpose of the IRF PPS was to replace the cost-based reimbursement system with one that focuses incentives on furnishing services on a more efficient basis. One of the underlying tenets of the prospective payment system is that providers are reimbursed for providing care based on average expected resource utilization for a certain diagnosis. Unfortunately, some of the changes proposed in the NPRM appear to shift back toward a cost-based reimbursement program. The proposed changes to the Rural Add-On Adjustment, the Low-Income Patient Adjustment, and the new Teaching Adjustment appear to be based on increases in costs since the implementation of IRF PPS. Some of these perceived increases in cost are very likely attributable directly to the omission of HealthSouth cost report data. However, prospective payment system rate changes are limited to factors such as inflation and observed changes in resource utilization. For example, the annual updates to the Inpatient PPS typically include a market basket update to the standard discharge payment amount, adjustments related to new diagnosis related groups (DRGs), and a recalibration of relative weights assigned to DRGs.

By contrast, some of the proposed payment adjustments contained in the NPRM appear to be based on relative changes in cost per case across different types of IRF providers. For example, the proposed modification to the Rural Add-On Adjustment is based on observed increases in cost differentials between urban and rural facilities. When the IRF PPS was implemented, CMS created a Rural Add-On Adjustment to address a 16% higher cost per case in the rural facilities compared to the national average. This rural adjustment is unique to the IRF PPS. Under other Medicare prospective payment system, facilities are required to manage costs in relation to expected payments. Similar concerns apply to other cost-based adjustments proposed in the NPRM. Although we are sensitive to the need for PPS payments to cover the costs and a reasonable return for efficient IRF providers in all settings, we believe that particular care must be taken to maintain incentives for all providers to pursue more efficient methods of delivering quality medical care.

II. Proposed Refinements to the Patient Classification System

A. Proposed Changes for updating the CMGs

This NPRM includes approximately nineteen (19) code changes to the IRF payment system. One of the most significant proposed changes is an update to the Patient Classification System and it's Case Mix Groups (CMGs). CMS is proposing to reduce the

number of CMGs from 95 in the current rule to 87 and at the same time change the functional scores that define each CMG. Included in the change of the functional scores is a proposed weighted Motor Score Index. Based on the results of analysis by RAND using 2003 data, it was reported the weighting of the motor score index improved the predictive ability of cost whereas weighting the cognitive score index did not. For these reasons, CMS proposed weighting the motor scores resulting in a motor score index that would classify patients into a CMG. We are very concerned with the concept of altering motor scores based on an "average optimal weight" as well as the overall changes in CMGs. Such changes represent a significant revision to the IRF PPS Patient Classification System.

When implementing IRF PPS, CMS developed the IRF PPS Patient Classification System by first examining the FIM-FRG methodology, a respected methodology widely used in IRFs. The FIM-FRG classified patients into one of 21 diagnostic categories which were then further subdivided into about 95 groups. Because the FIM-FRG system is based in part on the FIM, its classifications have been refined over the years using an abundance of FIM historical data. The NPRM now proposes to make a number of far-reaching changes to the current CMG system based on data drawn from a single year. We believe this will have serious consequences for several reasons.

1. First, the 2003 data used is not representative of the current IRF mix as a result of the 2004 changes in the 75% Rule.

2. Second, the GAO recently recommended that CMS encourage research to describe more precisely the subgroups of patients within a condition that require IRF services, possibly using functional status or other factors in addition to condition."[18] CMS agreed to this recommendation. Significant revision to the CMGs, including introducing a new weighted motor index should be delayed until such additional research is conducted. In addition, changes introduced with a weighted motor index score have the potential effect of disrupting years of historical comparative trending data for current and future research application.

3. Third, the basis of the current IRF PPS Patient Classification system, the FIM-FRG system, has been described by MedPAC as being "stable over time and predictive of length of stay and per discharge resource use."[19] MedPAC has also expressed confidence "in the validity of the patient groups and payment weights of the FIM-FRG system as the basis for a rehabilitation PPS." This assessment was similar to the conclusions of a 1997 RAND report, *Work Plan for an Inpatient Rehabilitation Prospective Payment System.* That report concluded that the FIM-FRG used the correct organizing concepts for a rehabilitation patient classification system and that

[18] General Accounting Office report on *Medicare – More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities.* April 24, 2005

[19] MedPAC, *March 1999 Report to the Congress: Medicare Payment Policy* (1999).

the FIM-FRG is a good predictor of resource use.[20] Recognizing the predictive validity of the patient groups of the current classification system, we strongly encourage CMS to preserve it's stability in the currently changing environment as well as preserve the consistency of the system for future research efforts.

Recommendation

We strongly recommend that CMS postpone both the implementation of the proposed weighted motor index and the proposed reduction in the number of CMGs until these concerns are adequately addressed.

B. Proposed Changes in Co-morbidities

CMS is also proposing to remove 25 co-morbid conditions from the current payment system. We recommend the following co-morbid conditions be preserved, based on associated increased costs related to each of the conditions according to our internal analysis.

- Code 260, 261 and 262 are all used to describe malnutrition affecting the elderly. Resources used for criteria for diagnosing and coding these conditions include Swails WS, Samour PQ, Babineu TJ, Bistain BR. *"A Proposed Revision of Current ICD-9-CM Malnutrition Code Definitions"* J Am Diet Assoc. 1996; 96:370-373; Funk K, Ayton C. *"Improving Malnutrition Documentation Enhances Reimbursement"* J Am Diet Assoc. 1995; 95:468-475. We recommend these codes continue to be retained as co-morbid conditions as they represent third degree malnutrition disorders that affect the elderly and, based on our internal analysis, have associated increased costs

- Code 799.4, Cachexia, a protein wasting syndrome, is seen in patients Rheumatoid Arthritis and other conditions admitted to IRF settings. An internal data analysis demonstrates an associated increase costs for treating those patients.

- Code 530.3 Esophageal stricture is so severe that patient's refuse to eat due to the overwhelming fear of something getting lodged in their esophagus. These patients are often placed on a liquid diet until this condition is resolved which can in itself lead to a malnourished state.

- Code 933.1 Foreign bodies in the larynx is also associated with increased costs. This code includes asphyxia due to foreign body and choking due to food or phlegm. This is a common occurrence in patients with difficulty swallowing prior to the diagnosis of dysphasia. This can also lead to aspiration pneumonia. This condition often results in a need to change the patient's diet.

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[20] *See* Grace M. Carter, *et al., A Classification System for Inpatient Rehabilitation Patients: A Review and Proposed Revisions to the Functional Independence Measure-Function Related Groups*, RAND, PM-682 (1997).

- The proposed V49.xx codes, amputations below the knee (BK), above the knee (AK) and at the Hip represent conditions that are excluded from the Amputation RIC (due to the fact that they are inherent in the condition). In the other RIC's where they are allowed, they do in fact affect the burden of care and progression of therapy. Therefore we recommend the following also not be excluded:

  - V49.75 Status Amputation BK
  - V49.76 Status Amputation AK
  - V49.77 Status Amputation Hip

Recommendation

We recommend retention of the codes described above due to their strong correlation to treatment costs.

C. Movement of Dialysis to Tier One

We concur with the proposal on page 30195 to move dialysis from Tier 2 to Tier 1.

III. Proposed FY 2006 Federal Prospective Payment Rates

A. Proposed Reduction of the Standard Payment Amount Account for Coding Changes

Under contract with CMS, RAND was asked to help identify potential refinements to the IRF PPS. As part of its work, RAND estimated that IRFs were paid approximately $140 million more than expected in calendar year 2002 as a result of changes in case-mix. RAND found it very difficult to separately determine the amount of the payment increase attributable to changes in patient acuity and the portion strictly related to improvements in coding. Two separate models were employed by RAND to get at the true impact of the coding changes. These models produced an estimated range of 1.9% to 5.9%. Based on these estimates, CMS elected to propose a one-time 1.9% downward adjustment to the Standard Payment Amount to account for the coding changes observed in the beginning years of PPS implementation. CMS also solicited further comments from the industry on this proposal.

We believe that the bulk of the observed coding changes can be explained by two factors: 1) an increase in the average case mix index for all IRFs following the implementation of the PPS, and 2) improved accuracy and consistency in coding by IRFs as a result of educational programs implemented by CMS in 2001 and 2002, particularly with respect to items that previously did not affect payments such as the presence of co-morbid conditions.[21] Either of

[21]Medicare Program - Inpatient Rehabilitation Facility Prospective Payment System; FY 2006 Proposed Rule, May 25, 2005 Federal Register Page 30220

these factors would justify increased payments under PPS. We therefore question whether any adjustment may be warranted at this time. First, the underlying analysis was done during a period of transition into the IRF PPS and prior to the implementation of the 75% Rule. Many providers were still learning and adjusting to the new payment system. Second, CMS has already applied a 1.16% behavioral offset to the initial Standard Payment Amount. Third, as described below, we believe that there is other credible information available to indicate that much of the increase in case mix and payments may have been attributable to increases in patient acuity caused by the incentives of the IRF PPS.

Use of Pre-75% Rule Baseline Data - As articulated above, CMS has recognized that IRF providers' cost structures may be changing as they work to comply with the new 75% Rule. However, CMS is basing the proposed 1.9% reduction on coding changes using FY 2002 and 2003 data, which includes data from discharges that would no longer qualify for admission under the criteria established by the new Rule. By relying on this data, it appears that CMS has not considered the substantial financial effect the new 75% rule is having and will have on IRF providers and Medicare beneficiaries in 2005 and beyond. Based on first and second quarter FY 2005 UDS_{MR} trended discharge data, we expect IRFs to admit approximately 39,600 fewer patients during the initial 50% compliance period. The American Medical Rehabilitation Providers Association has estimated a similar reduction in the number of cases for 2005. As described above, the loss of these cases will increase facility case mix and per case costs over time.

In addition, this data covers a time period when providers were transitioning to the IRF PPS. IRF facilities were reacting to the new payment system by changing coding practices and their underlying cost structures. The data gathered by CMS during this transitional time period may not be representative of current activity and should not be the foundation used to refine the IRF PPS.

In light of these concerns, CMS should carefully reconsider the validity of using pre-75% Rule cost and claims data as the basis for any reduction to the Standard Base Rate.

Previous Behavioral Offset - CMS has already adjusted the Standard Payment Amount for improved coding through an initial behavioral offset made in the implementation of IRF PPS. CMS reduced the Standard Payment Amount ($11,838) with a behavioral offset of 1.16% when IRF PPS was first implemented. This equated to a reduction of $139 (($11,838/.9884) - $11,838) per discharge, unadjusted for case-mix and wage index. CMS stated the behavioral offset "must account for change in practice patterns due to new incentives in order to maintain a budget neutral payment system. Efficient providers are adept at modifying and adjusting practice patterns to maximize revenues while still maintaining optimum quality of care for the patient. We take this behavior into account in the behavioral offset. Thus the purpose of the offset is not just to account for the behavior of the inefficient providers but also to account for the behavior of other providers who, due to

new incentives, provide more efficient care."[22] Whether or not this estimate may be sufficient to address the observed coding changes, the previous 1.16% rate reduction must be factored into any decision to reduce future expenditures. This same difference in estimate occurs each time CMS makes a market basket update. The actual expenditures differ in some cases from the best available data that CMS has to use at the time. There is no process or step in the PPS to correct errors in estimates.

Increased Patient Acuity - CMS recognizes that the "clinical coding of patient conditions in IRFs is vastly improved in the more recent data.[23] However, it also questions whether the changes reflect a change in average patient status. CMS has stated that (1) patients are not any "sicker" since implementation of IRF PPS, and that (2) lower admission FIM scores are more likely the result of behavioral changes and new FIM scoring guidelines. As these conclusions appear to be inconsistent with observations of rehabilitation physicians and clinicians, as well as our own internal data, we requested further data from two external sources to verify whether these observations and declining FIM scores at admission indicate that IRFs are treating a generally "sicker" population.

First, we requested data and analysis from the International Severity Information Systems, Inc. (ISIS) in relation to the question: Will analyses of Post-Stroke Rehabilitation Outcomes Project data clarify whether patient severity of illness levels is different Pre and Post IRF PPS implementation? ISIS conducted secondary analyses on a large multi-site study of stroke rehabilitation outcomes known as the Post-Stroke Rehabilitation Outcomes Project (PSROP). The study patient population consisted of 539 patients: 235 treated before and 304 treated after implementation of the prospective payment system (PPS) at 3 inpatient rehabilitation facilities, one in each of California, Utah, and Pennsylvania. Patient severity of illness levels were measured using the Comprehensive Severity Index (CSI®). CSI is an age- and disease-specific measure of physiologic complexity comprised of over 2,100 signs, symptoms, and physical findings, and is the most detailed measure of patient severity of illness in existence today. CSI enables clinicians and researchers to control for patient differences that might otherwise affect outcomes.

The analyses found significantly greater maximum CSI severity for patients treated post IRF PPS (indicating sicker patients) compared with pre-IRF PPS. This difference is clinically significant. Other differences were not significant but showed trends to greater severity post-PPS. For example there were more neurological/behavioral impairments post-IRF PPS.

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[22] Medicare Program – Prospective Payment System for Inpatient Rehabilitation Facilities; Final Rule, August 7, 2001 Federal Register Pages 41366 - 41367.

[23] Medicare Program - Inpatient Rehabilitation Facility Prospective Payment System; FY 2006 Proposed Rule May 25, 2005 Federal Register Page 30206

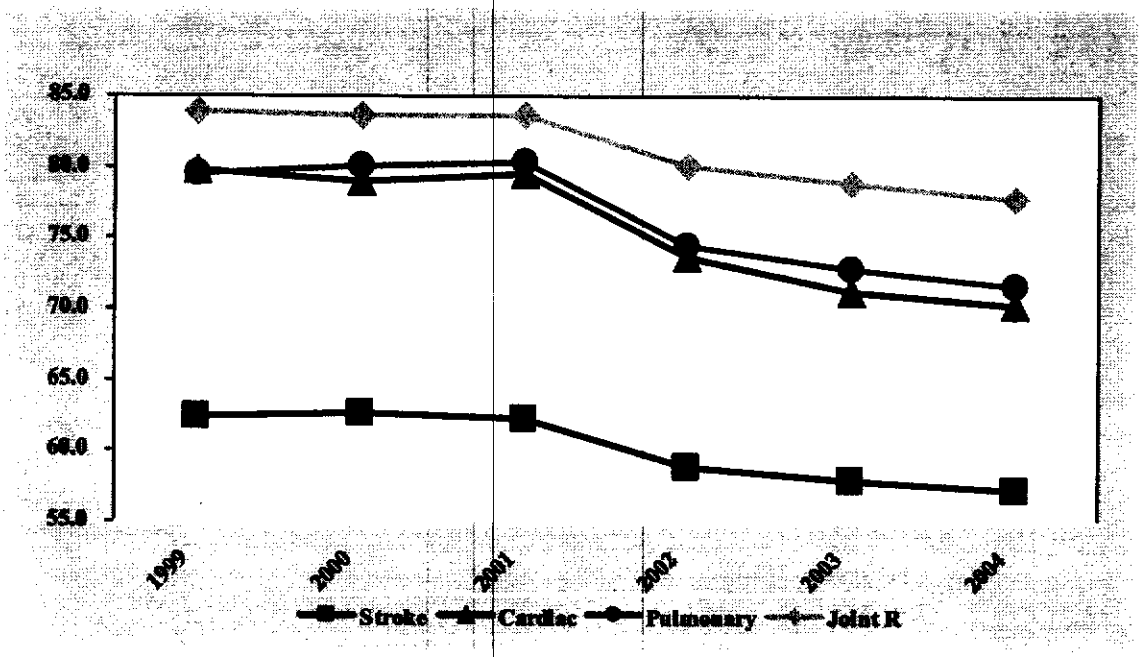
Variable	Pre PPS (Mean or %)	Post PPS (Mean or %)	P-value
Maximum CSI severity of illness score	**29.9**	**34.3**	**0.021**
Age at admission	66.0	65.7	0.828
LOS in Prior Acute Hospitalization	7.97	7.93	0.949
Discharged to SNF	17.0	19.7	0.709
Evidence of Depression	53.2	54.9	0.728
No neurological/behavioral impairments or related medications	26.4	20.1	0.167

We also requested data from UDS_{MR} in order to look at admission FIM scoring pre and post-PPS. Our analysis of this data indicated there were significant decreases in total FIM instrument ratings for both admissions and discharges from 1999 through 2004. The data analysis revealed that significant differences existed between FIM instrument ratings in 1999-2001 and 2002-2003, with lower total admission and discharge scores in 2002 and 2003 compared to 1999-2001. For example, the mean admission ratings for patients with stroke in 2001 was 62.2 (sd = 19.5) and in 2003, the mean admission FIM instrument ratings for persons with stroke was 57.8 (sd = 20.1). CMS appears to attribute this change due to minor modifications in the scoring system and procedures introduced in 2002 as part of the Inpatient Rehabilitation Facilities-Patient Assessment Instrument. We therefore analyzed other conditions, including Joint Replacement, Cardiac and Pulmonary conditions admitted to IRFs. In all four conditions the admission FIM score has declined for three consecutive fiscal years, an indication of increasing severity.

Table 13
Trending by Admission FIM for four conditions admitted to IRF

Condition	1999	2000	2001	2002	2003	2004
Stroke	Mean 62.3 SD 20.4	Mean 62.6 SD 19.8	Mean 62.2 SD 19.5	Mean 58.8 SD 20.3	Mean 57.8 SD 20.1	Mean 57.2 SD 19.8
Joint R	Mean 83.9 SD 11.5	Mean 83.6 SD 11.2	Mean 83.6 SD 10.8	Mean 80.1 SD 12.0	Mean 78.9 SD 12.1	Mean 77.8 SD 12.1
Cardiac	Mean 79.8 SD 16.3	Mean 79.0 SD 16.8	Mean 79.5 SD 15.9	Mean 73.7 SD 16.6	Mean 71.2 SD 16.3	Mean 70.3 SD 15.9
Pulmonary	Mean 79.6 SD 18.6	Mean 80.1 SD 16.9	Mean 80.3 SD 17.9	Mean 74.5 SD 17.3	Mean 72.8 SD 16.6	Mean 71.6 SD 16.2

Graph 9
Trending by Admission FIM for four conditions admitted to IRF



The consistent gradual decline in admission functional scores for three consecutive years indicates an increasing burden of care and a corresponding increasing severity for these four conditions.

Finally, we are concerned that CMS appears to tie the proposed reduction in the Standard Payment Rate to a 17% margin for the industry. As discussed above, the validity of this margin calculation is questionable if the underlying data omitted a substantial amount of the HealthSouth home office and depreciation cost in 2002 and 2003. It also fails to account for the implementation of substantial changes to the 75% Rule. Whatever the true industry margin may be (certainly lower than 17%), we expect to see declines over the next several years as IRFs treat a reduced number of medically complex cases and fixed costs will have to be absorbed over fewer annual discharges. Under these circumstances, we do not believe that historic margin rates calculated on incomplete data are able to offer a strong basis for any adjustment to base payment rates.

Recommendation

CMS concedes that determining the variables that contributed to the estimated $140 million increase IRF PPS payments may not be possible. We have outlined a number of reasons to question whether this reflects coding changes versus a gradual increase in average patient acuity. We therefore believe that CMS should delay implementation of any reduction to the standard payment amount until such time as the results of further analyses of acuity

trends in IRF admissions can be completed and the effects of the new 75% Rule on patients and providers are better understood.

B. Implementation of the Proposed Changes to Revise the Labor Market Areas

CMS has decided to adopt the Core Based Statistical Areas (CBSAs) as defined by the Office of Management and Budget. Micropolitan Areas will be included in the statewide rural labor market areas. Based on CMS' analysis, approximately 4% of the IRFs would change in either rural or urban designation. CMS concludes that 91% of the IRFs that switch from rural to urban under the CBSA definitions would experience an increase in their wage index, of which 74% of the IRFs would see an increase from 5% to 10%. A transition, similar to IPPS, has not been proposed since CMS believes the majority of the IRFs would not be significantly affected by the adoption of the CBSAs for the purpose of IRF PPS wage index.[24]

In discussing its reasons for not proposing a transition, CMS states that there are differences between IRF PPS and IPPS. IPPS has been operating under the full wage index since 1983 and has used the previous MSA definitions for the previous 10 years before the CBSA definitions were adopted; whereas IRF PPS started using the wage index for cost reporting periods beginning on or after January 1, 2002. CMS believes that many IRFs received the blended payment during the transition period and may still be adjusting to the changes in wage index. Thus they have not established a long enough history of an expected wage index from year to year. As a result, IRFs would not experience a significant effect on their respective wage indices because they are still adjusting to the prospective payment system. Analysis of the data by CMS suggests that the overall wage index effect between the MSA-based designations and the CBSA-based designations was not dramatic. Also, CMS comments that "unlike other post acute care payment systems, the IRF PPS payments apply a rural facility adjustment to account for higher costs in rural facilities."[25] Therefore, IRFs switching from urban to rural would receive the rural adjustment to offset any decrease in the wage index.

We disagree with CMS' decision not to propose a transition period related to the change from MSA-based definitions to CBSA-based definitions for IRF PPS wage index. With rural facilities becoming urban under the proposed CBSA-based labor market area designations, hospitals automatically lose the rural adjustment or 16.07% of their expected reimbursement. Even with a 10% increase in wage index, a hospital will lose 10.08% of its expected reimbursement due to the loss of the rural adjustment.

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[24]Medicare Program - Inpatient Rehabilitation Facility Prospective Payment System; FY 2006 Proposed Rule, May 25, 2005 Federal Register Page 30239

[25]Medicare Program - Inpatient Rehabilitation Facility Prospective Payment System; FY 2006 Proposed Rule, May 25, 2005 Federal Register Page 30240

HealthSouth has four (4) facilities that are reclassified from rural to urban under the proposed rules. Three of the four facilities will experience an increase of 8% to 11% in their wage index. The fourth facility will see a decrease in its wage index. Even though 3 of the facilities will experience an increase in their wage index, all four facilities will experience a significant decrease in expected reimbursement as a result of the loss of the 19.14% rural adjustment. Based on our analysis of the four HealthSouth facilities that will be designated as urban beginning October 1, 2005, the estimated loss in reimbursement is in excess of $7.5M.[26] The same observations should apply to other rural facilities designated as urban under the CBSA-based designations. Based on our review of the CMS rate file, this will affect as many as 35 facilities. Without addressing here the wisdom of a rural adjustment factor, we expect that many of these facilities will find it difficult to absorb revenue losses of this magnitude without a transition period to adjust the facility cost structure. Forcing facilities to undergo such dramatic changes in a single year seems unnecessary and could adversely affect local access to care.

Recommendation

We recommend that CMS reconsider the use of a transition period to avoid unexpected and unnecessary financial and operational dislocation to IRFs affected by the re-designation. We suggest a 3-year transition period similar to IPPS for rural hospitals designated as urban under the new CBSA-based labor market areas by reducing the rural adjustment 1/3 each year.

C. Changes to Labor-Related Share

As discussed earlier in this comment letter, CMS is proposing to increase the labor-related share from 72.359 percent in FY 2005 to the 75.958 percent in FY 2006. We believe that this amount may be misstated due to the exclusion of non-labor related home office and depreciation costs attributable to HealthSouth during FY 2002 and FY 2003.

D. Revision and Rebasing of the Market Basket

CMS is proposing to create a market basket exclusively for the rehabilitation, psychiatric and long term care hospitals (RPL). This will effectively remove childrens and cancer hospitals which tend to have less intensive labor cost structures. CMS proposes to use FY 2002 as the base period for constructing the new market basket. We support CMS in the development of Market Basket update factors that more accurately reflect the actual cost of care in inpatient rehabilitative facilities. We also recommend, similar to the Skilled Nursing Facility PPS, forecast errors of greater than .25% be adjusted in future rate updates. If FY 2002 is selected for the base period, market basket calculations will have to be adjusted to account for the omission of HealthSouth costs during that year.

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[26] See Appendix D for the impact analysis.

E. Proposed Teaching Status Adjustment

CMS is proposing to implement a teaching status payment adjustment for indirect medical education, along with a one time budget neutral adjustment of 0.9865 to be applied to the FY 2006 proposed standard payment amount. Upon implementation of IRF PPS in 2002, CMS chose not to implement a teaching adjustment because FY 1999 data did not indicate that indirect teaching costs were significant to warrant such an adjustment in the IRF PPS. In this proposed rule, CMS concluded that data from FY 2003 now indicates significant differences in cost of IRFs with teaching programs. CMS states that these higher costs warrant a teaching status adjustment, but there are some concerns. The concerns include the fact that the RAND analysis may reflect an aberration due to the use of only one year of data, and that implementation of the teaching adjustment should be equitable to all IRFs. There are no definitive conclusions available from CMS to explain why the FY 2003 conflicts with the 1999 results. We agree that the IRF PPS should reimburse providers for the variations in certain costs of providing necessary services. However, a more detailed analysis over multiple years and other considerations, such as additional payments for direct graduate medical education reimbursement need to be considered carefully before implementing a teaching status adjustment to the IRF PPS.

The recent RAND analysis did not distinguish between different types of resident specialties, nor did it distinguish the different types of services that the residents provided, because this data is not included in the cost reports. CMS had to estimate resident counts in the underlying data analysis as this was not available on all cost reports. HealthSouth believes it is an important factor to consider all data which is available via the IRIS database reported simultaneously with cost report submissions.

The new 75% Rule will also have a bearing on IRF cost per case. With the implementation of the new Rule, changes in programs at IRFs may result in a decrease of indirect teaching costs. For example, if there are less orthopedic cases due to patients not qualifying for IRF services under the 75% Rule, there will be fewer expenses associated with interns and residents for the hospital. CMS should consider the effects of the reduction of IRF cases in order for IRFs to be able to comply with the 75% rule, before the implementation of a teaching status adjustment.

CMS states that the RAND analysis indicated a statistically significant difference in costs between IRFs with teaching programs and those without teaching programs. CMS also states that more accurately coded data may have allowed RAND to determine better the differences in case mix among hospitals with and without teaching programs. CMS concludes that there are two reasons that indirect operating costs may be higher in teaching hospitals: (1) because the teaching activities themselves result in inefficiencies that increase costs, and (2) because patients needing more costly services tend to be treated in teaching hospitals than in non-teaching hospitals, the case mix index in such hospitals in higher.

Omission of HealthSouth home office and depreciation costs from the FY 2003 database likely accounts for a significant portion of the observed increase in the cost differential

between teaching and non-teaching IRFs. There is also reason to question whether the patient population served by teaching hospitals is significantly different than that served by the industry as a whole. Based on the FY 2003 CMS data analysis, the average case mix of IRFs with teaching programs was 0.9766. However, the average case mix index for HealthSouth facilities was actually higher at 1.1274. This would not be the case if teaching hospitals were, in fact, caring for sicker, higher acuity patients. We recommend that further consideration and analysis of all factors affecting the cost of care be considered prior to implementing a teaching adjustment.

We recognize that there may be a cost difference between teaching and non-teaching facilities. However, a large portion of the cost difference is reimbursed through the direct graduate medical education adjustment that is already in place for hospitals. Therefore, our analysis does not support CMS's conclusion that a teaching status adjustment should be implemented. We also question the basic assumption that teaching IRFs should receive additional reimbursement for operational inefficiencies attributable to teaching programs.

Finally, the CMS data indicates that most of the teaching hospitals are not-for-profit units. Many not-for-profits IRF units show a higher cost per case due to the overall hospital cost report overhead step-down to the unit, which is not necessarily indicative of true costs. CMS has cited this in the past as a basis for not recognizing cost differences between units and freestanding IRFs in the development of the IRF PPS. This should also be considered before implementing a teaching status adjustment.

Recommendation

HealthSouth concurs that further research is needed to determine if a teaching adjustment is warranted for indirect medical education (IME) cost. The omission of a material amount of HealthSouth cost from the FY 2002 and 2003 cost reports may indeed change the underlying regression analysis that supports the need for an additional payment. Changes from the 75% Rule may also affect these analyses. At this time, we do not believe that using one year's data is reliable enough to add a teaching adjustment and we recommend more research in the areas outlined above prior to implementing an adjustment for IME.

F. Proposed Adjustment for Disproportionate Share of Low-Income Patients

The Low-Income Payment (LIP) adjustment was included in the IRF PPS final rule published on August 7, 2001 with the belief that as a facility's percentage of low-income patient's increases, there is an incremental increase in the facility's cost. In determining the appropriate level of additional payments, the same measure of disproportionate patient percentage used for the acute care hospital inpatient prospective payment system was selected as the basis by which IRF payments would be adjusted to reflect each facility's disproportionate share (DSH) patient percentage. In the final rule, CMS stated that as other information becomes available it would take it into consideration and potentially refine the DSH adjustment in the future to ensure that facilities are paid in the most consistent and equitable manner.

As part of the proposed refinements to the IRF PPS for FY 2006, CMS is proposing a change to the LIP adjustment, from [(1 + DSH patient percentage) ^ 0.4838], to [(1 + DSH patient percentage) ^ 0.636]. Along with the change in the LIP adjustment, a one time budget neutral adjustment of 0.9836 would be applied to the FY 2006 proposed standard payment amount.

We agree with CMS that the LIP formula should be updated from time to time to reflect changes in the incremental costs of caring for low-income patients.[27] However, we do not believe that the data cited in the NPRM presents a compelling case that such incremental costs have increased significantly to warrant a change in the LIP adjustment.

Changing the calculation of the LIP adjustment will not affect total IRF costs to Medicare, but it will cause a significant redistribution of reimbursement among individual IRFs. Because the LIP adjustment is based in part on the percentage of Medicare patients eligible for Supplemental Security Income (SSI) and the percentage of eligible Medicaid patients who are not entitled to Medicare Part A benefits, IRFs serving a larger percentage of low-income patients will receive additional reimbursement from the LIP adjustment. CMS noted in the proposed rule that "RAND found little evidence that the patients admitted to IRFs in 2002 had higher resource needs (that is, more impairments, lower functioning, or more co-morbidities) than the patients admitted in 1999. RAND further stated in its technical report to CMS that even though the data would support a larger LIP adjustment than the one currently being used, it is "statistically indistinguishable from the (one) used under the current rule."[28] Absent a stronger demonstration that incremental costs associated with low-income patients have increased materially since 1999, we perceive no basis for changing the LIP formula or redistributing payments among IRFs.

Recommendation

We recommend that CMS delay any change to the LIP adjustment until the regression model confirms a material increase in the incremental cost of caring for low-income patients.

G. Proposed Update to the Outlier Threshold Amount

Since the inception of IRF PPS, three percent (3%) of total IRF expenditures has been set aside from the standard base payment rate to account for the expected additional costs of high-cost outliers cases. CMS stated in the 2001 IRF PPS Final Rule that it is important to set the outlier percentage so that it maximizes resources available for all types of cases while still protecting a facility from the financial risk associated with extremely high-cost cases.

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[27] Medicare Program - Inpatient Rehabilitation Facility Prospective Payment System; FY 2006 Proposed Rule, May 25, 2005 Federal Register Page 30245

[28] Paddock SM, Carter GM, Wynn, BO, and Zhou AJ; Possible Refinements to the Facility-Level Payment Adjustments for the Inpatient Rehabilitation Facility Prospective Payment System, RAND Health, page 12.

CMS further stated that the results of financial risk, accuracy at the case level, and accuracy at the hospital level suggest that there should be a limit on the outlier percentage that is less than the statutory limit and that balances the need to compensate accurately for high-cost care while still maximizing remaining resources to improve the payment accuracy of non-outlier cases. CMS adopted a three percent outlier policy and estimated the outlier threshold in the initial PPS payment year at $11,211.[29] This outlier threshold has remained constant for FY 2003, FY 2004 and FY 2005 IRF PPS periods without regard to actual payment outlays.

We are concerned that the outlier policy has never paid out the full amount of the three percent outlier reserve. CMS estimates that only 1.2% of 3% in estimated payments allotted for outlier payments will be paid in FY 2005.[30] This means that providers will be underpaid by approximately $113M in FY 2005 alone for outlier payments because of the current methodology used to estimate high-cost outlier cases. Projecting this experience, it is possible that CMS may have underpaid providers by as much as $460 million for outlier payments since inception of the IRF PPS system. We do not believe that this practice is consistent with the congressional purpose of the outlier program.

We therefore support changes to the current outlier program that will ensure that all outlier funds are distributed to providers rather than remaining with CMS. However, we have concerns that the proposal to decrease the threshold from $11,211 to $4,911 may disproportionately reward facilities with excessive cost to charge ratios. The establishment of such a low outlier threshold will in effect qualify many cases that would not meet the regulatory intent of an outlier payment. We believe that setting too low of an outlier threshold will distort the overall balance of an efficient PPS system and create incentives for the retention of patients longer than is clinically appropriate. Unless this proposed adjustment is eliminated, a majority of IRFs will see a redistribution of reimbursement in favor of less efficient providers.

Recommendation

Based on the concerns raised above, we recommend that CMS adopt an alternative to the lower outlier threshold. The Secretary is authorized, but not required, to provide for additional payments for outlier cases. We recommend that CMS retain the FY 2005 outlier threshold of $11,211 and return the remaining 1.8% (the portion expected to remain unexpended in FY 2005) to the base payment rate. The redistribution of $113 million from the outlier pool to the base rate would mitigate some of the impact of the proposed payment reductions and ensure the system does not offer incentives to inefficient providers. A permanent reduction in the outlier pool is justified by the fact that these monies have never been expended by CMS and the system has been operating efficiently. Setting the outlier

[29] Medicare Program – Prospective Payment System for Inpatient Rehabilitation Facilities; Final Rule, August 7, 2001 Federal Register Pages 41361 – 41362.

[30] Medicare Program – Inpatient Rehabilitation Facility Prospective Payment System; FY 2006 Proposed Rule, May 25, 2005 Federal Register Page 30266

pool and case thresholds at adequate levels will protect the overall structure and efficiency of the IRF PPS system.

We recommend that CMS monitor this issue closely. If there is evidence that access is being affected for some patient populations or that specific providers experiencing significant harm because of a disproportionate share of high cost outliers, modifications to the outlier percentage should be considered.

H. Proposed Adjustment for Rural Location

The Rural Location Adjustment was initially included in the IRF PPS final rule as an additional payment for rural IRFs. The rural adjustment factor used by CMS to adjust for physical location of the IRF has remained constant at 19.14% of the wage and case-mix adjustment standard payment amount per discharge. In the proposed IRF PPS rule for FY 2006, CMS has proposed changing the rural adjustment factor to 24.1%. Also, CMS has proposed a budget neutrality adjustment to the standard payment amount of 0.9963 to offset this change. The increase in the rural adjustment factor appears to be based on a regression analysis performed by RAND using 2003 data showing that rural facilities now "have 24.1% percent higher costs of caring for Medicare patients than urban facilities"[31]

We believe that the Rural Location Adjustment is overstated based on the omission of the HealthSouth home office and depreciation costs. Because the majority of the our facilities are classified as urban for rate setting purposes, the effect of the data omission on a regression analysis could be substantial.

We agree that all Medicare beneficiaries who reside in rural areas deserve access to quality inpatient rehabilitative care. In supporting the implementation of the rural adjustment, CMS stated the data shows that the "standardized cost per case [adjusted for wage index and case-mix] for rural IRFs is almost 16 percent higher than the national average."[32] According to RAND's updated research, the actual cost per discharge is only slightly higher for rural IRFs when compared to urban IRFs ($11,543 versus $11,143) despite the fact that urban IRFs have a average 19.6% higher wage index value than rural IRFs.[33] By statute, payment rates for IRF PPS must be adjusted to reflect geographic wage differences. Without the Rural Location Adjustment, rural IRFs would be reimbursed significantly less than costs to treat Medicare patients based on the standard payment amount. We question whether it is reasonable to use the Rural Location Adjustment to offset the effects of the lower wage index values in the rural areas. After application of the adjustment, the average

[31]Medicare Program - Inpatient Rehabilitation Facility Prospective Payment System for FY 2006 Proposed Rule, May 25, 2005 Federal Register Page 30244

[32] Medicare Program – Prospective Payment System for Inpatient Rehabilitation Facilities; Final Rule, August 7, 2001 page 41359.

[33] Paddock SM, Carter GM, Wynn, BO, and Zhou AJ; Possible Refinements to the Facility-Level Payment Adjustments for the Inpatient Rehabilitation Facility Prospective Payment System, RAND Health, page 13

reimbursement per case for rural facilities becomes sufficient to cover costs and continue to provide access to inpatient rehabilitative care.

Like other prospective payment systems used by Medicare (IPPS, OPPS, and LTCH), IRF PPS facility payments are based, in part, on geographic wage variations (wage index). Each year the wage index values are updated and incorporated into the different prospective payment systems. However, none of these other payment systems provide for an additional payment adjustment based on the rural status of the provider. When the Long Term Acute Care PPS was implemented, wage index was phased in over a five-year period to allow hospitals time to bring their cost structures in line with other hospitals in their census regions. All of these prospective payment systems require facilities to respond to the changes in the wage index factors and adapt their operations to account for the changes in reimbursement based on the market factors where the facilities are located (*e.g.*, to compete for staffing in local markets). As in the case of the proposed LIP adjustment, the NPRM and the RAND data analyses which omit over $100 million of HealthSouth home office and depreciation costs, provide an insufficient basis for redistribution of reimbursement of this magnitude between urban and rural providers.

Recommendation

CMS should recalculate the rural adjustment after incorporation of the missing HealthSouth cost report data. This should substantially reduce the proposed 24.1% payment add-on. Additionally, we recommend that CMS calculate the rural adjustment in a way that creates incentives for low cost, high quality providers. Our experience has been that the cost to operate a rural hospital in comparison to an urban hospital is far less than the payment adjustment already in place. As an interim step, we believe that CMS should freeze the 19.14% adjustment. Additional research should be conducted to determine whether any rural adjustment is necessary to ensure access to needed rehabilitative care in these settings and if so, how to calculate a payment level tied to the costs of an efficient provider.

I. Budget Neutrality Adjustments

Any changes or postponement to the proposed adjustments in the rule will also require the corresponding budget neutrality amounts to be modified.

J. Table 3 – Errors in Table

Provider Name errors were noted in Table 3 – Inpatient Rehabilitation Facilities with Corresponding State and County Location; Current Labor Market Area Designation' and Proposed New CBSA-Based Labor Market Area Designation. These corrections have been shared in our response.[34]

[34] See Appendix E

CBSA-Based Designation errors were noted in Table 3 – Inpatient Rehabilitation Facilities with Corresponding State and County Location; Current Labor Market Area Designation' and Proposed New CBSA-Based Labor Market Area Designation. These corrections have been shared on Appendix E.

IV. Additional Comments

A. Additional Research Warranted

The Government Accountability Office (GAO) report on the IRF Classification Rule suggested that further "refinement" of the IRF PPS be based on further credible research.[35] HealthSouth continues to strongly support the need to perform further research prior to making substantial changes and refinements to the IRF PPS. We have taken action to fund two research projects aimed at providing much needed information on the characteristics of appropriate IRF admissions. The findings from these research projects are expected to provide useful information that could be used to identify appropriate refinements to the IRF PPS.

B. Quality Bench-Marking Initiatives and Single Post-Acute Payment System

We appreciate the discussion in the NPRM of CMS's interest in examining approaches aimed at achieving integration within the post-acute care continuum, and also paying inpatient rehabilitation hospitals based upon the quality of care they provide. HealthSouth is supportive of these concepts and has shared with CMS a set of preliminary proposals for a demonstration project designed to assess the feasibility of developing a uniform patient assessment tool that could be applied across multiple post acute settings.

As the NPRM notes, the process of developing an integrated patient assessment tool is complex. We believe CMS should implement a demonstration program designed to test basic concepts in this area. If it is successful, the data elements of such a demonstration can serve as the foundation for a patient assessment instrument that can be applied universally within the major settings across the post-acute continuum of care.

We also support the implementation of a separate "pay-for-performance" demonstration within inpatient rehabilitation settings. Such a demonstration could be based upon patient outcome measures that would be used to establish risk-adjusted clinical performance benchmarks. The outcome measurements and benchmarks could serve as the basis for public comparisons among inpatient rehabilitation providers and provide incentives for the provision of high quality care via their incorporation into a "pay-for-performance" framework.

We welcome continued dialogue in both of these areas, and stand ready to collaborate with CMS and the post-acute care community to encourage more effective integration across

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[35] General Accounting Office report on *Medicare – More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities.* April 24, 2005

post-acute settings generally and to promote high-quality care within the IRF sector specifically.

C. CMS Rate Setting File Review

We have completed a financial summary impact of the CMS rate setting file sorted by facility type.[36] Our analyses of this data highlightsthe CMS figures clearly orchestrate the extensive negative financial effect of proposed Rule will have on urban for-profit freestanding facilities. We believe that any refinement of the IRF PPS should be balanced and not materially alter or shift payments significantly from one facility type to another without sound basis for these redistributions. The CMS analysis also indicates there will be a large shift in CMG weights causing over a $70M swing in payments between urban for-profit and urban not-for-profit facilities. Redistribution of payments of this magnitude must be rationalized by changes in the case mix or cost per case. We can only conclude that the omission of our cost data is materially altering the distribution in the CMG weights and the underlying fairness of the refinements being proposed by CMS.

Conclusion

We appreciate CMS' efforts to improve the IRF PPS. While we recognize the need to continue to refine the components of the system, we strongly believe that any material changes must be based on complete data supported by sound analysis. Unfortunately, the majority of the changes recommended in the proposed rule fail to meet this test. Omission of more than $100 million of total IRF industry costs from the CMS/RAND database (heavily weighted toward urban facilities) as well as the failure to quantify case mix and unit cost changes related to the new 75% Rule, highlight serious flaws in the supporting analyses.

We respectfully request the Secretary postpone any material refinements to the system at this time. A standard IRF payment update should not occur until such time as more research is available and the data that is utilized to recalibrate the payment system takes into account the changes made by the new 75% Rule.

We thank you for the opportunity to comment on this proposed rule and look forward to working with CMS to make further improvements in the IRF PPS.

Sincerely,

Justin Hunter
Vice President, Government and
Regulatory Affairs

[36] See Appendix F

BCC: Jay Grinney
Mike Snow
John Workman
John Markus
Greg Doody
Mark Tarr
Frank DiCesare
Jean Davis
Justin Hunter
Rob Wisner
Tom Fox
Scot Hasselman

Appendix A

75% Rule

Projected Medicare Savings FY 2005 - Updated

	IRF Cases Reduced	Net Medicare Savings
Original CMS estimate ($ only)	~ 1,750 [a]	$10 million
FY 2005 industry projection (UDSmr data)	~ 39,600 [b]	$226 million
AMRPA estimates of annual impact	~ 39,000 [c]	not provided

[a] CMS estimate, $10 million, divided by $5,710, the "net savings" per case reduction due to movement to SNF, Home Health, etc. (Rate per Fed. Reg. Vol. 69, No. 89 pg 25772)

[b] Reflects actual results from UDSmr database for the first two quarters of FY2005. Remaining quarters are projections using Q2 FY2005 trend

[c] AMRPA press release, April 23, 2005

Appendix A

Uniform Data System Report* Quarterly Compare 2002 thru 2005

MEDICARE ONLY

		2002					2003					2004					2005	
		Q1 N	Q2 N	Q3 N	Q4 N	TOTAL N	Q1 N	Q2 N	Q3 N	Q4 N	TOTAL N	Q1 N	Q2 N	Q3 N	Q4 N	TOTAL N	Q1 N	TOTAL N
1	Stroke	12,112	12,418	12,128	11,970	48,628	12,048	12,033	11,665	11,570	47,316	11,922	11,539	11,438	11,629	46,528	11,797	11,797
2	Brain Dysfuction, Traumatic	904	952	898	983	3,737	936	966	1,043	1,049	3,994	1,109	1,130	1,119	1,307	4,665	1,267	1,267
3	Brain Dysfuction, Non-Traumatic	1,370	1,416	1,448	1,471	5,705	1,389	1,570	1,454	1,577	5,990	1,622	1,629	1,707	1,722	6,680	1,844	1,844
4	Spinal Cord Dysfuction, Traumatic	347	383	408	371	1,509	327	381	372	341	1,421	362	380	413	377	1,532	346	346
5	Spinal Cord Dysfuction, Non-Traumatic	2,068	2,391	2,281	2,335	9,075	2,302	2,460	2,546	2,657	9,965	2,355	2,600	2,655	2,559	10,169	2,364	2,364
6	Neurological Conditions	2,986	3,011	2,882	3,034	11,913	2,883	3,058	3,128	3,063	12,132	3,211	3,303	3,392	3,679	13,585	3,837	3,837
7	Lower Extremity Fracture	8,137	8,162	8,280	8,516	33,095	8,792	8,738	8,714	9,089	35,333	9,137	8,830	8,707	9,259	35,933	9,010	9,010
8	Lower Extremity Joint Replacement	15,573	16,321	16,358	17,460	65,712	16,365	17,437	17,123	18,296	69,221	16,641	17,855	16,548	16,788	67,832	14,446	14,446
9	Other Orthopedic	3,349	3,562	3,657	4,014	14,582	4,008	3,986	4,027	4,152	16,173	4,095	4,166	3,978	4,006	16,245	3,690	3,690
10	Amputation, Lower Extremity	1,912	1,849	1,936	1,776	7,473	1,772	1,879	1,867	1,721	7,239	1,827	1,936	1,885	1,733	7,381	1,764	1,764
11	Amputation, Non-Lower Extremity	190	231	210	171	802	189	206	241	195	831	186	172	137	125	620	124	124
12	Osteoarthritis	1,553	1,403	1,359	1,330	5,645	1,337	1,361	1,296	1,127	5,121	1,048	1,093	901	687	3,729	573	573
13	Rheumatoid and Other Arthritis	627	702	655	732	2,716	665	738	719	789	2,911	751	833	566	507	2,457	475	475
14	Cardiac	4,219	4,417	4,106	4,446	17,188	4,490	4,385	4,118	4,325	17,318	4,452	4,298	3,759	3,596	16,105	3,270	3,270
15	Pulmonary	2,282	1,818	1,380	1,421	6,901	1,714	1,598	1,232	1,370	5,914	1,931	1,524	1,098	1,028	5,581	1,476	1,476
16	Pain Syndrome	1,518	1,571	1,569	1,640	6,298	1,480	1,582	1,474	1,413	5,949	1,388	1,320	1,346	1,304	5,358	1,037	1,037
17	MMT without Brain/Spinal Cord Injury	725	810	779	861	3,175	772	798	823	792	3,185	751	741	712	707	2,911	630	630
18	MMT with Brain/Spinal Cord Injury	175	155	173	187	690	171	169	169	193	702	188	167	172	204	731	172	172
19	Guillain-Barre	116	111	101	78	406	121	96	99	121	437	107	88	97	93	385	99	99
20	Miscellaneous	8,364	8,621	8,883	9,192	35,060	9,564	9,152	9,047	9,169	36,932	9,874	9,313	8,574	7,869	35,730	7,625	7,625
21	Burns	52	43	34	40	169	51	46	34	43	174	59	52	41	32	184	47	47
	Total	68,579	70,347	69,525	72,028	280,479	71,376	72,639	71,191	73,052	288,258	73,016	72,769	69,345	69,211	284,341	65,893	65,893

ALL PAYERS

		2002					2003					2004					2005	
		Q1 N	Q2 N	Q3 N	Q4 N	TOTAL N	Q1 N	Q2 N	Q3 N	Q4 N	TOTAL N	Q1 N	Q2 N	Q3 N	Q4 N	TOTAL N	Q1 N	TOTAL N
1	Stroke	17,438	18,119	17,579	17,623	70,759	17,574	17,718	17,259	17,161	69,712	17,627	17,242	17,198	17,450	69,517	17,793	17,793
2	Brain Dysfuction, Traumatic	2,214	2,369	2,452	2,550	9,585	2,239	2,450	2,697	2,630	10,016	2,460	2,656	2,902	3,014	11,032	2,856	2,856
3	Brain Dysfuction, Non-Traumatic	2,588	2,731	2,678	2,768	10,765	2,744	2,893	2,785	2,915	11,337	3,034	3,089	3,254	3,206	12,583	3,290	3,290
4	Spinal Cord Dysfuction, Traumatic	1,062	1,151	1,276	1,228	4,717	1,104	1,142	1,287	1,201	4,734	1,087	1,102	1,296	1,305	4,770	1,193	1,193
5	Spinal Cord Dysfuction, Non-Traumatic	3,365	3,716	3,596	3,717	14,393	3,648	3,912	3,912	4,089	15,561	3,709	4,031	4,110	3,988	15,838	3,747	3,747
6	Neurological Conditions	4,065	4,109	4,052	4,138	16,364	4,062	4,200	4,374	4,241	16,877	4,439	4,537	4,633	4,948	18,557	5,189	5,189
7	Lower Extremity Fracture	9,674	9,730	10,007	10,148	39,559	10,604	10,457	10,533	10,890	42,484	10,944	10,644	10,435	11,144	43,167	10,823	10,823
8	Lower Extremity Joint Replacement	21,705	23,196	23,006	24,913	92,820	23,286	24,900	24,199	25,905	98,290	23,538	24,994	22,784	23,364	94,680	19,892	19,892
9	Other Orthopedic	4,367	4,772	4,870	5,333	19,362	5,331	5,270	5,389	5,488	21,478	5,386	5,453	5,182	5,280	21,301	4,916	4,916
10	Amputation, Lower Extremity	2,597	2,714	2,742	2,579	10,632	2,591	2,683	2,716	2,530	10,520	2,693	2,746	2,708	2,645	10,792	2,567	2,567
11	Amputation, Non-Lower Extremity	256	334	270	232	1,092	266	284	324	273	1,147	268	223	191	170	852	164	164
12	Osteoarthritis	1,756	1,600	1,570	1,533	6,459	1,526	1,571	1,464	1,288	5,849	1,198	1,278	1,027	753	4,256	641	641
13	Rheumatoid and Other Arthritis	765	847	810	901	3,323	830	907	901	960	3,598	911	810	724	664	3,109	600	600
14	Cardiac	4,853	5,036	4,747	5,069	19,705	5,156	5,015	4,731	4,913	19,815	5,066	4,894	4,324	4,149	18,433	3,724	3,724
15	Pulmonary	2,679	2,187	1,654	1,711	8,231	2,043	1,937	1,462	1,635	7,077	2,284	1,821	1,291	1,243	6,639	1,755	1,755
16	Pain Syndrome	1,996	2,104	2,102	2,196	8,398	2,009	2,101	1,961	1,866	7,937	1,808	1,754	1,785	1,707	7,054	1,331	1,331
17	MMT without Brain/Spinal Cord Injury	1,761	2,025	2,251	2,263	8,300	2,114	2,109	2,370	2,252	8,845	2,009	2,197	2,175	2,115	8,496	1,800	1,800
18	MMT with Brain/Spinal Cord Injury	978	1,096	1,255	1,293	4,622	1,053	1,138	1,362	1,245	4,798	1,139	1,168	1,346	1,344	4,997	948	948
19	Guillain-Barre	320	311	302	292	1,225	333	276	301	312	1,222	335	287	267	261	1,150	308	308
20	Miscellaneous	10,413	10,806	11,064	11,506	43,789	11,952	11,451	11,228	11,372	46,003	12,200	11,544	10,719	9,875	44,338	9,518	9,518
21	Burns	158	169	168	166	661	175	173	155	169	672	179	203	195	155	732	151	151
	Total	95,030	99,122	98,450	102,159	394,761	100,640	102,587	101,410	103,335	407,972	102,294	102,673	98,546	98,780	402,293	93,116	93,116

These trends are based on the same facilities having cases in each quarter reviewed. (611)
The data represents discharged cases
The data may include future refinements which have the possibility of changing from non-qualifying to qualifying or vice versa.
Extrapolations are made by the Federation

***This summary information was provided by UDSMR, for the benefit of the rehabilitation field, and is used with prior written permission of UDSMR.**

Updated May 9, 2005

Appendix A

Volume Variance from Prior Fiscal Years (Medicare Only)

	Fiscal Year 2003	Fiscal Year 2004	Projected Fiscal Year 2005 (1)	Var FY 03 vs. FY 05	% Var FY 03 vs. FY 05	Var FY 04 vs. FY 05	% Var FY 04 vs. FY 05
Cases	287,234	288,182	263,354	(23,880)	(8.31%)	(24,828)	(8.62%)

- **The data represents discharged cases.**
- **Data Derived from facilities reporting discharges in each quarter (611). Data represents approximately 63% of Medicare IRF discharges**
- **This summary information was provided by UDSmr, for the benefit of the rehabilitation field, and is used with prior written permission of UDSmr**

(1) **FY 2005 Projection reflects actual results from UDSmr database for first two quarters of FY 2005. Remaining quarters are projected using Q2 FY 2005 trend**

Appendix B

Development of Missing HealthSouth Cost Numbers

We estimate that approximately $197M in 2002 and $176M in 2003 in allowable costs were excluded from HealthSouth cost reports. This estimation is derived from the following assumptions:

1. FY 2004 Medicare allowable home office costs assigned to each facility is assumed to be representative of FY 2002 and FY 2003 Medicare allowable home office costs.

2. 70% of total depreciation expense for each HealthSouth facility is considered allowable for Medicare purposes. We have based the 70% assumption taking an estimate of the impact of the financial restatement and the necessary adjustments relating to regulations in the fixed asset area of the Provider Reimbursement Manual (including DEFRA and asset recordation issues).

3. Calculated as the net effect of all Working Trial Balance changes that impact the filed Medicare cost for the given year (positive and negative adjustments combined).

Medicare's estimated share of these expenses is $115 million in 2002 and $111M in 2003. Medicare's share is calculated by dividing the allowable portion of Medicare inpatient patient costs found on Worksheet D-1, Line 49 by total allowable costs on W/S B, Part I, Column 27, line 103 of each facilities Medicare cost report. This percentage was multiplied by total estimated allowable costs to arrive at Medicare's share of the total expense.

Estimate of Home Office and Depreciation Costs excluded for FY 2002 Medicare Cost Reports
HealthSouth

Appendix B

		A	B=A*.70	C	D	E=B+C+D	F	G	H=G/F	I=H*E
Provider		Total Depreciation Offset	Estimated adjustment of depreciation to FAL(70% of depreciation)	2004 Home Office	Net Impact of Restatement Entries[1]	Total Expense excluded from Cost Reports	Total Cost (w/s B Pt 1 col 27, line 103)	Medicare I/P Cost (w/s D-1 line 49)	% of Medicare cost to total cost	Estimated Medicare Portion
263028	The Rehabilitation Institute of St. Louis	1,011,544	708,081	2,376,859	(43,518)	3,041,422	14,261,005	4,493,150	31.51%	958,247
293026	HEALTHSOUTH REHABILITATION HOSPITAL OF LAS VEGAS	437,664	306,365	4,173,131	288,167	4,767,663	13,206,511	7,338,972	55.57%	2,649,431
293032	HEALTHSOUTH Rehabilitation Hospital of Henderson	703,784	492,649	1,832,857	2,115,743 [3]	4,441,249	7,838,254	4,669,219	59.57%	2,645,635
303027	HEALTHSOUTH REHABILITATION HOSPITAL	899,336	629,535	1,459,314	135,786	2,224,635	9,312,005	6,328,590	67.96%	1,511,898
313029	HEALTHSOUTH REHABILITATION HOSPITAL OF NEW JERSEY	1,418,117	992,682	2,767,954	398,928	4,159,563	27,565,669	14,991,391	54.38%	2,262,149
313035	Rehabilitation Hospital of Tinton Falls	330,986	231,690	1,324,141	993,580 [3]	2,549,411	4,343,225	2,655,639	61.14%	1,558,822
323027	HEALTHSOUTH REHABILITATION HOSPITAL	458,419	320,893	1,409,848	(283,063)	1,447,678	10,002,325	4,626,944	46.26%	669,677
393026	HEALTHSOUTH REHAB HOSPITAL OF READING	633,266	443,286	1,285,290	173,678	1,902,254	14,023,143	6,606,781	47.11%	896,217
393027	HEALTHSOUTH HARMARVILLE REHABILITATION HOSPITAL	1,205,445	843,812	2,866,436	368,288	4,078,536	25,048,735	11,343,323	45.29%	1,846,965
393031	HEALTHSOUTH REHAB OF MECHANICSBURG -ACUTE REHAB	1,588,037	1,111,626	2,237,423	192,019	3,541,068	25,482,861	12,862,152	50.47%	1,787,309
393037	HEALTHSOUTH REHABILITATION HOSP YORK	826,249	578,374	2,397,868	401,927	3,378,169	18,778,723	10,364,499	55.19%	1,864,506
393039	HEALTHSOUTH NITTANY VALLEY REHABILITATION HOSPITAL	783,991	548,794	1,954,595	338,069	2,841,458	12,842,991	6,583,806	51.26%	1,456,640
393040	HEALTHSOUTH OF ALTOONA, INC	908,345	635,842	1,722,375	521,357	2,879,574	16,621,535	7,814,483	47.01%	1,353,809
393045	HEALTHSOUTH REHABILITATION HOSPITAL OF SEWICKLEY	556,459	389,521	1,229,156	64,851	1,683,528	7,534,061	3,697,707	49.08%	826,273
393046	HEALTHSOUTH REHABILITAION HOSPITAL OF ERIE	1,075,562	752,893	2,623,061	109,200	3,485,154	17,569,653	10,173,416	57.90%	2,018,021
393047	GEISINGER HEALTHSOUTH REHABILITATION HOSPITAL	134,051	93,836	659,054	(126,264)	626,626	8,385,961	3,794,151	45.24%	283,511
403025	HEALTHSOUTH REHABILITATION HOSPITAL	399,537	279,676	610,470	(22,645)	867,501	4,066,617	2,511,759	61.77%	535,815
423025	HEALTHSOUTH REHABILITATION HOSPITAL OF COLUMBIA	1,196,141	837,299	1,982,449	247,564	3,067,312	14,291,034	9,221,980	64.53%	1,979,331
423026	HEALTHSOUTH REHAB HOSP OF FLORENCE	1,154,111	807,878	1,706,226	353,184	2,867,288	11,406,265	8,757,793	76.78%	2,201,519
423027	HEALTHSOUTH OF CHARLESTON, INC	425,882	298,117	740,294	346,322	1,384,733	8,446,293	5,448,947	64.51%	893,331
423028	HEALTHSOUTH REHABILITATION HOSPITAL	455,766	319,036	896,086	(16,261)	1,198,861	7,194,971	3,560,597	49.49%	593,284
423029	ANMED HEALTHSOUTH REHABILITATION HOSPITAL	-	-	850,132	-	850,132	-	-		-
443027	HEALTHSOUTH REHABILITATION HOSPITAL	669,885	468,920	1,035,021	69,665	1,573,605	6,977,689	4,082,575	58.51%	920,700
443028	Vanderbilt Stallworth Rehabilitation Hospital	878,003	614,602	934,109	(322,679)	1,226,032	12,310,535	5,578,923	45.32%	555,617
443029	HEALTHSOUTH REHABILITATION CENTER OF MEMPHIS	808,379	565,865	2,068,926	(556,294)	2,078,497	13,358,397	8,104,602	60.67%	1,261,034
443030	HEALTHSOUTH CANE CREEK REHAB HOSPITAL	507,297	355,108	734,169	(30,482)	1,058,795	5,446,682	3,921,434	72.00%	762,298
443031	HEALTHSOUTH REHABILITATION HOSPITAL -NORTH	330,383	231,268	912,611	770,200 [3]	1,914,080	4,435,400	3,431,230	77.36%	1,480,734
453029	HEALTHSOUTH REHABILITATION HOSPITAL	378,165	264,716	649,730	261,086	1,175,532	8,344,655	5,914,916	70.88%	833,249
453031	HEALTHSOUTH REHAB INSTITUTE OF SAN ANTONIO	-	-	2,240,087	290,809	2,530,896	16,972,432	8,992,073	52.98%	1,340,880
453040	HEALTHSOUTH REHABILITATION HOSPITAL OF ARLINGTON	-	-	1,814,714	(121,510)	1,693,204	12,571,083	6,635,886	52.79%	893,790
453041	FORT WORTH REHABILITATION HOSPITAL	-	-	1,154,994	126,443	1,281,437	9,754,245	5,712,457	58.56%	750,458
453042	HEALTHSOUTH City View Rehabilitation Hospital	697,734	488,414	2,070,884	(35,360)	2,523,938	13,204,620	6,679,405	50.58%	1,276,705
453044	HEALTHSOUTH REHAB HOSP OF AUSTIN	-	-	1,814,651	823,160	2,637,811	15,812,021	8,464,878	53.53%	1,412,137
453047	HEALTHSOUTH PLANO REHABILITATION HOSP	-	-	2,289,514	770,984	3,060,498	13,292,719	7,786,541	58.58%	1,792,763
453048	HEALTHSOUTH REHABILITATION HOSPITAL	198,968	139,278	1,138,644	(101,817)	1,176,105	10,728,215	8,060,563	75.13%	883,657
453053	HEALTHSOUTH REHABILITATION HOSPITAL OF TEXARKANA	-	-	1,239,122	192,659	1,431,781	9,932,773	6,915,722	69.63%	996,882
453054	HEALTHSOUTH REHAB HOSPITAL OF WICHITA FALLS	168,828	118,180	2,524,739	69,754	2,712,672	8,704,131	6,721,493	77.22%	2,094,776
453056	HEALTHSOUTH REHABILITATION HOSPITAL OF TYLER	156,175	109,323	3,080,751	4,532	3,194,606	9,392,984	7,218,963	76.85%	2,455,209
453057	HEALTHSOUTH REHABILITATION OF MIDLAND ODESSA	-	-	1,144,698	232,010	1,376,708	9,042,964	7,222,045	79.86%	1,099,490
453059	HEALTHSOUTH REHAB HOSPITAL OF NORTH HOUSTON	543,302	380,311	1,492,547	488,568	2,361,426	9,598,131	7,222,168	75.25%	1,776,869
450758	Dallas Medical Center	-	-	3,054,276	-	3,054,276	24,885,988	8,703,936	34.98%	1,068,241
463025	HEALTHSOUTH REHABILITATION HOSPITAL OF UTAH	894,176	625,923	1,688,634	198,702	2,513,259	11,549,023	6,761,781	58.55%	1,471,476
493028	HEALTHSOUTH REHABILITATION HOSPITAL OF VIRGINIA	-	-	1,028,529	153,257	1,181,786	8,080,429	5,726,415	70.87%	837,505
493029	UVA-HEALTHSOUTH Rehabilitation Hospital	-	-	1,462,673	16,810	1,479,484	8,633,852	4,952,156	57.36%	848,594

Estimate of Home Office and Depreciation Costs excluded for FY 2002 Medicare Cost Reports
HealthSouth

Appendix B

Provider		A Total Depreciation Offset	B=A*.70 Estimated adjustment of depreciation to FAL(70% of depreciation)	C 2004 Home Office	D Net Impact of Restatement Entries[1]	E=B+C+D Total Expense excluded from Cost Reports	F Total Cost (w/s B Pt 1 col 27, line 103)	G Medicare I/P Cost (w/s D-1 line 49)	H=G/F % of Medicare cost to total cost	I=H*E Estimated Medicare Portion
513026	HEALTHSOUTH Southern Hills Rehabilitation Hospital	660,204	462,143	1,276,996	164,454	1,903,593	8,602,405	6,910,498	80.33%	1,529,197
513027	HEALTHSOUTH WESTERN HILLS REGIONAL REHAB HOSPITAL	547,392	383,174	886,027	223,417	1,492,618	7,805,507	5,508,468	70.57%	1,053,364
513028	H/S REHAB HOSPITAL OF HUNTINGTON	601,340	420,938	1,025,433	79,860	1,526,231	6,682,944	5,045,945	75.50%	1,152,378
513030	HEALTHSOUTH MOUNTAINVIEW REGIONAL REHAB HOSPITAL	354,172	247,920	1,668,339	190,862	2,107,121	16,397,853	10,063,576	61.37%	1,293,168
453090[2]	HEALTHSOUTH Rehabilitation Hospital of Odessa	-	-	284,130	-	284,130	-	-		-
01T064	HEALTHSOUTH Lakeshore Carraway Rehabilitation Unit	-	-	223,931	(127,824)[3]	96,107	3,405,721	2,455,787	72.11%	69,301
44T162	HEALTHSOUTH Chattanooga Rehabilitation Hospital	775,081	542,557	1,257,650	112,075	1,912,281	9,514,865	7,443,106	78.23%	1,495,903
Total - 20 Patient Rehabilitation Facilities		$ 48,268,647	$ 33,788,053	$ 154,797,495	$ 8,252,140	$ 196,837,688	$ 1,125,392,491	$ 665,119,303		$ 115,448,363

[1] Restated Depreciation not included since expense was offset 100% on the cost reports

[2] Provider #'s 01-3033 & 45-3090: 1st cost reports filed in 2004

[3] manually changed for odd years, start ups

KEY

A *Booked Depreciation amount offset on w/s A-8 (if 0, then the depreciation was adjusted to Medicare books on the cost report)*

B *70% of A- assuming 30% disallowed in restatement process*

C *Home Office Allocation based upon as-filed 2004 Home Office Cost Report*

D *Net change in as-filed versus restated less depreciation changes (included change in Management Fees)*

Estimate of Home Office and Depreciation Costs excluded for FY 2003 Medicare Cost Reports **Appendix C**

HealthSouth

Provider		A Total Depreciation Offset	B=A*.70 Estimated adjustment of depreciation to FAL(70% of depreciation)	C 2004 Home Office	D Net Impact of Restatement Entries[1]	E=B+C+D Total Expense excluded from Cost Reports	F Total Cost (w/s B Pt 1 col 27, line 103)	G Medicare I/P Cost (w/s D-1 line 49)	H=G/F % of Medicare cost to total cost	I=H*E Estimated Medicare Portion
013025	HEALTHSOUTH LAKESHORE REHABILITATION HOSPITAL	-	-	1,614,576	(1,253,831)	360,745	21,060,769	13,508,956	64.14%	231,392
013028	HEALTH SOUTH REHAB HOSPITAL OF MONTGOMERY	606,540	424,578	1,920,995	5,013	2,350,586	12,642,672	10,152,492	80.30%	1,887,600
013029	HEALTHSOUTH REHAB HOSP OF NORTH ALA	-	-	835,594	28,009	863,603	10,087,395	7,048,292	69.87%	603,419
013030	HEALTHSOUTH REHABILITATION HOSPITAL	-	-	945,190	15,063	960,253	6,372,938	4,665,957	73.22%	703,051
013032	HEALTHSOUTH Rehabilitation Hospital of Gadsden	-	-	845,202	95,696	940,898	6,244,353	5,325,632	85.29%	802,465
033025	HEALTHSOUTH MERIDIAN POINT REHAB HOSP	556,867	389,807	785,899	(13,517)	1,162,189	8,425,295	5,247,651	62.28%	723,863
033028	HEALTHSOUTH REHAB INSTITUTE OF TUCSON	1,086,970	760,879	2,050,633	41,637	2,853,149	14,467,618	9,361,214	64.70%	1,846,118
033029	HEALTHSOUTH REHAB HOSPITAL	162,993	114,095	1,080,377	(150,712)	1,043,760	12,858,489	8,265,813	64.28%	670,960
033032	HEALTHSOUTH VALLEY OF THE SUN	924,644	647,251	1,818,831	(30,321)	2,435,761	11,379,604	6,826,019	59.98%	1,461,083
033034	YUMA REHABILITATION HOSPITAL	295,978	207,185	934,413	132,924[3]	1,274,522	4,837,342	3,801,911	78.60%	1,001,711
043028	HEALTHSOUTH REHABILITATION HOSPITAL	1,209,623	846,736	2,417,024	(58,811)	3,204,949	9,698,887	7,666,036	79.04%	2,533,203
043029	HEALTHSOUTH REHABILITATION HOSPITAL OF JONESBORO	815,584	570,909	2,044,762	(292,020)	2,323,651	10,424,188	7,766,870	74.51%	1,731,309
043031	ST. ALEXIUS HOSPITAL	183,381	128,367	972,490	(223,490)	877,367	8,675,405	5,599,096	64.54%	566,251
043032	HEALTHSOUTH REHAB HOSP IN PART WITH RE	228,766	160,136	1,262,565	(160,991)	1,261,710	12,368,929	7,742,833	62.60%	789,819
053031	HEALTHSOUTH BAKERSFIELD REHAB HOSPITAL	1,062,859	744,001	1,858,937	(187,866)	2,415,073	11,833,540	7,785,976	65.80%	1,589,017
053034	HEALTHSOUTH TUSTIN REHABILITATION HOSP	53,245	37,272	1,101,694	(341,997)	796,968	16,187,188	9,690,931	59.87%	477,128
063030	HEALTHSOUTH REHAB HOSP OF COLORADO SPGS	304,804	213,363	1,192,195	(61,087)	1,344,471	11,109,379	8,307,429	74.78%	1,005,376
103028	HEALTHSOUTH SUNRISE REHABILITATION HOSPITAL	1,636,197	1,145,338	3,844,430	(496,649)	4,493,119	30,235,225	17,861,388	59.07%	2,654,299
103031	HEALTHSOUTH REHAB HOSPITAL	911,942	638,359	2,258,684	(182,365)	2,714,678	16,934,230	11,666,454	68.89%	1,870,216
103032	HEALTHSOUTH TREASURE COAST REHAB HOSPITAL	1,039,042	727,329	2,480,815	(183,996)	3,024,148	18,405,990	14,328,225	77.85%	2,354,162
103033	HEALTHSOUTH REHAB HOSPITAL OF TALLHASSEE	371,926	260,348	1,818,829	43,314	2,122,491	14,265,352	10,774,151	75.53%	1,603,048
103034	HEALTHSOUTH SEA PINES REHABILITATION HOSPITAL	894,813	626,369	2,154,200	53,266	2,833,835	15,655,000	10,420,626	66.56%	1,886,320
103037	HEALTHSOUTH REHABILITATION HOSPITAL	366,094	256,266	1,213,203	(105,768)	1,363,701	15,963,631	10,628,707	66.58%	907,962
103038	HEALTHSOUTH REHAB HOSPITAL OF MIAMI	501,466	351,026	1,506,090	(49,928)	1,807,188	12,553,399	4,374,981	34.85%	629,823
103040	HEALTHSOUTH EMERALD COAST REHABILITATION HOSPITAL	792,454	554,718	1,651,229	4,139	2,210,085	11,479,554	8,752,591	76.25%	1,685,081
103042	HEALTHSOUTH REHAB HOSP OF SPRING HILL	328,434	229,904	1,223,369	152,527[3]	1,605,800	5,311,998	4,606,610	86.72%	1,392,563
113027	HEALTHSOUTH CENTRAL GA REHAB HOSPITAL	262,279	183,595	927,109	(172,741)	937,964	14,409,984	10,079,570	69.95%	656,092
013033[2]	Regional Rehabilitation Hospital	-	-	858,519	-	858,519	-	-	0.00%	-
143028	Van Matre Healthsouth Rehabilitation Hospital	546,425	382,498	1,158,165	(321,639)	1,219,024	8,153,280	4,856,206	59.56%	726,067
153025	HEALTHSOUTH TRI-STATE REHABILITATION HOSPITAL	188,205	131,744	901,974	28,591	1,062,309	11,454,535	8,543,668	74.59%	792,351
173025	Kansas Rehabilitation Hospital	139,720	97,804	810,335	(53,528)	854,611	7,856,788	6,001,173	76.38%	652,769
173026	Mid America Rehabilitation Hospital	219,878	153,915	1,366,777	(92,174)	1,428,518	13,936,502	8,521,213	61.14%	873,440
173027	Wesley Rehabilitation Hospital, An Affiliate of HEALTHSOUTH	146,076	102,253	929,663	40,159	1,072,075	9,755,519	5,978,646	61.28%	657,019
183027	HEALTHSOUTH NORTHERN KENTUCKY REHABILITATION	-	-	1,044,296	(36,023)	1,008,273	7,909,069	5,373,160	67.94%	684,988
183028	HEALTHSOUTH REHAB HOSP OF CENTRAL KY	-	-	962,393	(532,554)	429,839	7,443,700	5,681,310	76.32%	328,069
193028	HEALTHSOUTH Rehabilitation Hospital of Baton Rouge	989,828	692,880	2,002,097	(55,603)	2,639,374	9,431,726	4,554,177	48.29%	1,274,441
193031	HEALTHSOUTH REHABILITATION HOSPITAL OF ALEXANDRIA	316,443	221,510	2,152,544	(244,588)	2,129,466	7,217,814	4,824,348	66.84%	1,423,324
203025	NEW ENGLAND REHABILITAION HOSPITAL-WOBURN	-	-	1,291,405	(1,133,322)	158,083	18,910,618	12,986,960	68.68%	108,564
213028	HEALTHSOUTH CHESAPEAKE REHAB HOSPITAL	521,600	365,120	1,062,811	(219,335)	1,208,596	8,326,989	6,179,428	74.21%	896,894
223026	HEALTHSOUTH New England Rehab Hospital	325,478	227,835	3,282,957	(1,054,417)	2,456,375	44,543,814	27,011,799	60.64%	1,489,569
223027	HEALTHSOUTH BRAINTREE REHAB HOSPITAL	-	-	8,854,103	274,693[3]	9,128,796	49,407,105	25,068,050	50.74%	4,631,745
223029	FAIRLAWN REHABILITATION HOSPITAL	-	-	1,258,116	1,191,788[3]	2,449,904	19,589,978	12,925,270	65.98%	1,616,422
223030	HEALTHSOUTH REHAB HOSP OF WESTERN MA	448,047	313,633	1,094,755	(55,030)	1,353,358	13,598,953	7,789,979	57.28%	775,253
263027	Howard A. Rusk Rehabilitation Center	688,617	482,032	1,705,702	(809,581)	1,378,153	11,028,906	3,801,980	34.47%	475,089
263028	The Rehabilitation Institute of St. Louis	1,076,654	753,658	2,376,859	(72,477)	3,058,040	17,126,155	6,565,679	38.34%	1,172,365

Estimate of Home Office and Depreciation Costs excluded for FY 2003 Medicare Cost Reports **Appendix C**

HealthSouth

Provider		A Total Depreciation Offset	B=A*.70 Estimated adjustment of depreciation to FAL(70% of depreciation)	C 2004 Home Office	D Net Impact of Restatement Entries[1]	E=B+C+D Total Expense excluded from Cost Reports	F Total Cost (w/s B Pt 1 col 27, line 103)	G Medicare I/P Cost (w/s D-1 line 49)	H=G/F % of Medicare cost to total cost	I=H*E Estimated Medicare Portion
293026	HEALTHSOUTH REHABILITATION HOSPITAL OF LAS VEGAS	393,027	275,119	4,173,131	(125,590)	4,322,660	15,260,917	9,312,207	61.02%	2,637,686
293032	HEALTHSOUTH Rehabilitation Hospital of Henderson	788,151	551,706	1,832,857	(88,685)	2,295,877	11,802,135	7,243,380	61.37%	1,409,060
303027	HEALTHSOUTH REHABILITATION HOSPITAL	674,337	472,036	1,459,314	(95,619)	1,835,731	10,102,968	6,969,321	68.98%	1,266,340
313029	HEALTHSOUTH REHABILITATION HOSPITAL OF NEW JERSEY	1,279,371	895,560	2,767,954	(316,629)	3,346,885	28,369,017	16,875,563	59.49%	1,990,924
313035	Rehabilitation Hospital of Tinton Falls	642,515	449,761	1,324,141	99,408	1,873,310	8,497,171	5,759,813	67.79%	1,269,824
323027	HEALTHSOUTH REHABILITATION HOSPITAL	-	-	1,409,848	(455,678)	954,170	11,412,326	5,952,421	52.16%	497,674
393026	HEALTHSOUTH REHAB HOSPITAL OF READING	537,208	376,046	1,285,290	(174,286)	1,487,050	14,622,333	7,178,518	49.09%	730,035
393027	HEALTHSOUTH HARMARVILLE REHABILITATION HOSPITAL	1,066,026	746,218	2,866,436	(243,198)	3,369,456	26,502,830	12,906,900	48.70%	1,640,928
393031	HEALTHSOUTH REHAB OF MECHANICSBURG -ACUTE REHAB	1,373,860	961,702	2,237,423	(633,268)	2,565,857	26,400,017	13,900,468	52.65%	1,351,007
393037	HEALTHSOUTH REHABILITATION HOSP YORK	737,470	516,229	2,397,868	(238,571)	2,675,526	19,792,519	11,296,090	57.07%	1,526,990
393039	HEALTHSOUTH NITTANY VALLEY REHABILITATION HOSPITAL	675,288	472,702	1,954,595	(369,580)	2,057,716	13,993,625	7,029,200	50.23%	1,033,621
393040	HEALTHSOUTH OF ALTOONA, INC	817,246	572,072	1,722,375	38,201	2,332,648	17,882,752	9,034,065	50.52%	1,178,414
393045	HEALTHSOUTH REHABILITATION HOSPITAL OF SEWICKLEY	530,486	371,340	1,229,156	(21,978)	1,578,518	7,605,074	3,439,374	45.22%	713,881
393046	HEALTHSOUTH REHABILITAION HOSPITAL OF ERIE	934,102	653,871	2,623,061	(157,481)	3,119,452	18,580,246	10,662,741	57.39%	1,790,176
393047	GEISINGER HEALTHSOUTH REHABILITATION HOSPITAL	139,309	97,516	659,054	(225,268)	531,302	8,908,351	3,548,411	39.83%	211,631
403025	HEALTHSOUTH REHABILITATION HOSPITAL	384,192	268,934	610,470	(51,065)	828,339	4,774,414	2,246,290	47.05%	389,721
423025	HEALTHSOUTH REHABILITATION HOSPITAL OF COLUMBIA	1,064,102	744,871	1,982,449	(85,892)	2,641,429	13,909,996	9,183,393	66.02%	1,743,874
423026	HEALTHSOUTH REHAB HOSP OF FLORENCE	868,323	607,826	1,706,226	(50,058)	2,263,994	12,091,364	9,580,764	79.24%	1,793,908
423027	HEALTHSOUTH OF CHARLESTON, INC	356,429	249,500	740,294	(72,952)	916,843	8,835,425	5,783,181	65.45%	600,114
423028	HEALTHSOUTH REHABILITATION HOSPITAL	432,671	302,870	896,086	(81,735)	1,117,221	7,534,184	4,670,325	61.99%	692,548
423029	ANMED HEALTHSOUTH REHABILITATION HOSPITAL	338,622	237,035	850,132	123,259[3]	1,210,426	4,909,888	3,275,622	66.71%	807,534
443027	HEALTHSOUTH REHABILITATION HOSPITAL	552,315	386,621	1,035,021	(54,298)	1,367,344	7,284,474	4,513,511	61.96%	847,216
443028	Vanderbilt Stallworth Rehabilitation Hospital	-	-	934,109	35,352[3]	969,461	13,115,933	6,198,968	47.26%	458,195
443029	HEALTHSOUTH REHABILITATION CENTER OF MEMPHIS	784,846	549,392	2,068,926	(845,769)	1,772,549	13,484,243	8,435,119	62.56%	1,108,825
443030	HEALTHSOUTH CANE CREEK REHAB HOSPITAL	410,905	287,634	734,169	1,669,130	2,690,933	5,454,178	4,110,537	75.36%	2,028,019
443031	HEALTHSOUTH REHABILITATION HOSPITAL -NORTH	440,252	308,176	912,611	(200,315)	1,020,472	6,528,609	5,224,950	80.03%	816,700
450758	Dallas Medical Center	1,525,376	1,067,763		-	1,067,763	25,613,049	10,760,550	42.01%	448,588
453029	HEALTHSOUTH REHABILITATION HOSPITAL	269,240	188,468	649,730	(69,345)	768,853	9,207,564	6,854,147	74.44%	572,337
453031	HEALTHSOUTH REHAB INSTITUTE OF SAN ANTONIO	1,168,622	818,035	2,240,087	(180,264)	2,877,858	15,938,718	8,077,094	50.68%	1,458,381
453040	HEALTHSOUTH REHABILITATION HOSPITAL OF ARLINGTON	1,050,782	735,547	1,814,714	(81,918)	2,468,344	12,818,344	7,044,805	54.96%	1,356,572
453041	FORT WORTH REHABILITATION HOSPITAL	627,620	439,334	1,154,994	(153,015)	1,441,313	10,151,136	5,895,238	58.07%	837,038
453042	HEALTHSOUTH City View Rehabilitation Hospital	889,086	622,360	2,070,884	(296,111)	2,397,133	13,832,549	7,207,272	52.10%	1,248,995
453044	HEALTHSOUTH REHAB HOSP OF AUSTIN	-	-	1,814,651	99,932	1,914,583	16,374,956	9,349,484	57.10%	1,093,155
453047	HEALTHSOUTH PLANO REHABILITATION HOSP	210,103	147,072	2,289,514	58,467	2,495,053	13,212,912	7,787,347	58.94%	1,470,520
453048	HEALTHSOUTH REHABILITATION HOSPITAL	178,772	125,140	1,138,644	39,859	1,303,643	11,503,359	8,989,807	78.15%	1,018,789
453053	HEALTHSOUTH REHABILITATION HOSPITAL OF TEXARKANA	740,781	518,547	1,239,122	(175,634)	1,582,035	10,590,318	7,724,731	72.94%	1,153,959
453054	HEALTHSOUTH REHAB HOSPITAL OF WICHITA FALLS	142,357	99,650	2,524,739	102,091	2,726,480	9,007,762	7,509,121	83.36%	2,272,869
453056	HEALTHSOUTH REHABILITATION HOSPITAL OF TYLER	138,362	96,853	3,080,751	28,742	3,206,346	10,593,117	7,967,249	75.21%	2,411,543
453057	HEALTHSOUTH REHABILITATION OF MIDLAND ODESSA	636,194	445,336	1,144,698	(98,040)	1,491,993	9,540,844	7,727,040	80.99%	1,208,351
453059	HEALTHSOUTH REHAB HOSPITAL OF NORTH HOUSTON	488,959	342,271	1,492,547	(90,102)	1,744,717	9,924,176	7,911,556	79.72%	1,390,889
463025	HEALTHSOUTH REHABILITATION HOSPITAL OF UTAH	771,508	540,056	1,688,634	20,611	2,249,300	13,074,742	7,620,833	58.29%	1,311,043
493028	HEALTHSOUTH REHABILITATION HOSPITAL OF VIRGINIA	444,678	311,275	1,028,529	(32,148)	1,307,655	8,390,616	6,167,068	73.50%	961,121
493029	UVA-HEALTHSOUTH Rehabilitation Hospital	562,083	393,458	1,462,673	(13,761)	1,842,370	8,465,450	5,035,668	59.48%	1,095,933
513026	HEALTHSOUTH Southern Hills Rehabilitation Hospital	582,450	407,715	1,276,996	3,290	1,688,001	10,051,505	7,959,274	79.18%	1,336,642
513027	HEALTHSOUTH WESTERN HILLS REGIONAL REHAB HOSPITAL	440,590	308,413	886,027	(67,027)	1,127,413	8,342,086	5,771,802	69.19%	780,045

Estimate of Home Office and Depreciation Costs excluded for FY 2003 Medicare Cost Reports

Appendix C

HealthSouth

Provider		A Total Depreciation Offset	B=A*.70 Estimated adjustment of depreciation to FAL(70% of depreciation)	C 2004 Home Office	D Net Impact of Restatement Entries[1]	E=B+C+D Total Expense excluded from Cost Reports	F Total Cost (w/s B Pt 1 col 27, line 103)	G Medicare I/P Cost (w/s D-1 line 49)	H=G/F % of Medicare cost to total cost	I=H*E Estimated Medicare Portion
513028	H/S REHAB HOSPITAL OF HUNTINGTON	462,820	323,974	1,025,433	(78,888)	1,270,519	7,401,058	5,846,836	79.00%	1,003,710
513030	HEALTHSOUTH MOUNTAINVIEW REGIONAL REHAB HOSPITAL	312,729	218,910	1,668,339	318,677	2,205,926	19,796,618	11,904,864	60.14%	1,326,552
453090[2]	HEALTHSOUTH Rehabilitation Hospital of Odessa	-	-	284,130	-	284,130	-	-	0.00%	-
01T064	HEALTHSOUTH Lakeshore Carraway Rehabilitation Unit	-	-	223,931	(1,552)[3]	222,379	3,118,855	2,260,866	72.49%	161,203
44T162	HEALTHSOUTH Chattanooga Rehabilitation Hospital	659,060	461,342	1,257,650	(48,772)	1,670,220	10,547,854	8,479,719	80.39%	1,342,737
Total - Inpatient Rehabilitation Facilities		**$ 48,727,097**	**$ 34,108,968**	**$ 151,743,219**	**$ (9,877,016)**	**$ 175,975,170**	**$ 1,214,732,382**	**$ 765,102,960**	**62.16%**	**$ 110,637,518**

[1] Restated Depreciation not included since expense was offset 100% on the cost reports

[2] Provider #'s 01-3033 & 45-3090: 1st cost reports filed in 2004

[3] manually changed for odd years, start ups

KEY

A *Booked Depreciation amount offset on w/s A-8 (if 0, then the depreciation was adjusted to Medicare books on the cost report)*

B *70% of A- assuming 30% disallowed in restatement process*

C *Home Office Allocation based upon as-filed 2004 Home Office Cost Report*

D *Net change in as-filed versus restated less depreciation changes (included change in Management Fees)*

Analysis of Reimbursement Effect on HealthSouth Providers Reclassified from Rural to Urban

Appendix D

Provider No	Provider Name	Cases	MSA Wage Index Factor	CBSA Wage Index Factor	Estimted Payments before Wage Index and Rural Adjustment Changes	Estimated Effect from Wage Index	Estimated Effect from Loss of Rural Adjustment[1]	Net Effect	% Net Effect	% Effect - Wage Index	% Effect - Rural Adjustment	% Change in Wage Index Value
103032	Treasure Coast	1,164	0.8721	0.9477	$ 19,314,864	$ 983,491	$ (3,321,318)	$ (2,337,827)	-12.10%	5.09%	-17.20%	8.67%
513030	Mountain View	1,272	0.8083	0.8730	20,763,555	1,376,919	(3,625,846)	(2,248,927)	-10.83%	6.63%	-17.46%	8.00%
213028	Chesapeake	783	0.9179	0.9123	11,305,188	(1,845)	(1,851,856)	(1,853,701)	-16.40%	-0.02%	-16.38%	-0.61%
183028	Lakeview	609	0.7844	0.8684	9,703,335	620,467	(1,689,528)	(2,309,995)	-23.81%	6.39%	-23.81%	10.71%
	Total Hospitals	3,828			$ 61,086,942	$ 2,979,032	$ (10,488,548)	$ (7,509,516)	-12.29%	4.88%	-17.17%	

[1] The 0.9963 Rural Add On Budget Neutrality Adjustment is included in the estimated calculation.

Appendix E

Table 3 – Inpatient Rehabilitation Facilities with Corresponding State and County Location; Current Labor Market Area Designation' and Proposed New CBSA-Based Labor Market Area Designation:

Provider No.	Provider Name Per Table 3	Correct Provider Name
513026	Southern Indiana Rehabilitation Hospital	HEALTHSOUTH Southern Hills Rehabilitation Hospital
223026	New Hanover Regional Medical Center	HEALTHSOUTH New England Rehab Hospital
263027	Rutland Regional Medical Center	Howard A. Rusk Rehabilitation Center
493029	Valley Baptist Health System Rehab Unit	UVA-HEALTHSOUTH Rehabilitation Hospital
173025	Kansas University Rehab Hospital	Kansas Rehabilitation Hospital
173026	Middletown Regional Hospital	Mid America Rehabilitation Hospital
173027	Wesley Woods Geriatric Hospital	Wesley Woods Rehabilitation Hospital
193028	Rehab Institute at Santa Barbara	HEALTHSOUTH Rehabilitation Hospital of Baton Rouge
453042	Temple University Hospital	HEALTHSOUTH City View Rehabilitation Hospital
263028	Rehabilitation Patient Care Unit	The Rehabilitation Institute of St. Louis
140328	Vanderbilt Stallworth Rehab Hospital	Van Matre HealthSouth Rehabilitation Hospital
313035	Rehabilitation Institute at Morristown Memorial	Rehabilitation Hospital of Tinton Falls
01T064	Lakeway Regional Hospital	HEALTHSOUTH Lakeshore Carraway Rehabilitation Unit
013033	Regions Hospital Rehab Institute	Regional Rehabilitation Institute
443028	VCUHS	Vanderbilt Stallworth Rehabilitation Hospital

Table 3 – Inpatient Rehabilitation Facilities with Corresponding State and County Location; Current Labor Market Area Designation' and Proposed New CBSA-Based Labor Market Area Designation

Provider No.	Provider Name	Per Table 3 CBSA Code	Correct CBSA Code
103034	HEALTHSOUTH Sea Pines Rehabilitation Hospital	22744	37340
193031	HEALTHSOUTH Rehabilitation Hospital of Alexandria	29340	10780
013033	Regions Hospital Rehab Institute	33860	17980

Analysis of CMS IRF 2006 Rate Setting File (Excluding Effects of Outlier Payments)

Appendix F

	Urban - For Profit - Free Standing	Urban - For Profit - Units	Rural - For Profit - All Types	Urban - Government - All Types	Rural - Government - All Types	Urban - Not For Profit - Free Standing	Urban - Not For Profit - Units	Rural - Not For Profit - All Types	Totals
3.1% Market Basket Adjustment	49,395,297	17,682,287	5,052,223	11,947,866	2,352,760	18,950,243	76,613,760	9,345,488	191,339,924
1.9% Decrease "Coding Change" Adjustment	(31,209,964)	(11,172,391)	(3,192,200)	(7,549,149)	(1,486,570)	(11,973,537)	(48,407,699)	(5,904,860)	(120,896,370)
0.9995 WI BNA	(614,369)	(219,929)	(62,839)	(148,605)	(29,263)	(235,700)	(952,907)	(116,237)	(2,379,850)
Change in Labor Component	(2,504,888)	(178,188)	(1,304,055)	(94,943)	(607,477)	(37,002)	357,809	(1,997,156)	(6,365,909)
Change in Wage Index Factor	1,253,599	1,962,161	(2,906,446)	120,909	(338,735)	(637,074)	2,392,056	(1,076,441)	770,028
0.9836 LIP BNA	(26,417,883)	(9,456,945)	(2,702,059)	(6,390,028)	(1,258,317)	(10,135,080)	(40,975,021)	(4,998,209)	(102,333,541)
Change in LIP Formula	21,754,162	11,107,203	3,116,293	8,792,731	1,558,659	10,568,119	39,304,360	4,049,173	100,250,700
0.9963 Rural Add On BNA	(5,897,946)	(2,111,318)	(603,250)	(1,426,611)	(280,927)	(2,262,716)	(9,147,912)	(1,115,879)	(22,846,558)
Change in Rural Add On	(10,332,866)	(2,624,413)	10,090,541	(2,270,585)	3,806,191	(1,331,264)	(7,788,807)	19,705,580	9,253,977
0.9865 IME BNA	(21,257,180)	(7,609,542)	(2,174,215)	(5,141,743)	(1,012,506)	(8,155,204)	(32,970,598)	(4,021,814)	(82,342,803)
Addition of IME Reimbursement	4,794,782	1,425,242	-	15,131,500	-	8,413,195	53,356,392	688,297	83,809,409
0.9956 CMG BNA	(860,117)	(307,901)	(83,974)	(208,047)	(40,968)	(329,979)	(1,334,070)	(162,732)	(3,331,790)
Change in CMG Weights	(41,395,751)	1,863,753	661,610	2,370,241	1,064,061	1,509,779	31,750,777	5,621,250	3,445,721
	(63,293,133)	360,021	5,887,628	15,133,134	3,726,909	4,343,781	62,198,139	20,016,460	48,372,938

NRH
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ATTN.: CMS-1290-P

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule. Federal Register, Volume 70, No. 100, Wednesday, May 25, 2005

Dear Dr. McClellan:

Northeast Rehabilitation Hospital appreciates the opportunity to comment on the proposed rule for the Inpatient Rehabilitation Facility Prospective Payment System for FY 2006 as published in the Federal Register on May 25, 2005. Northeast Rehabilitation Hospital (NRH) is a 102-bed acute rehabilitation facility offering comprehensive inpatient physical rehabilitation programs for both adults and children. We are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and serve patients from New Hampshire, Massachusetts, and surrounding areas. We are concerned that the proposed rule will significantly impact rehabilitation hospitals in New Hampshire. We respectfully request that CMS address this issue in the final rule.

Background

The implementation of the new Metropolitan Statistical Areas (MSA), as determined under the proposed new Core-Based Statistical Areas (CBSA) labor market area definition, using the standards developed for the 2000 Census have had a uniquely negative effect on the rehabilitation hospitals in the State of New Hampshire. These new standards, which radically altered the existing requirements for what constituted a Metropolitan Statistical Area, resulted in the Greater Boston MSA being broken up into six smaller MSAs. This outcome was unique to the Boston region: no other geographic areas suffered the same fate.

When CMS opted to use these new CBSA designations for the rehabilitation hospital Medicare inpatient reimbursement payment system, numerous facilities in Massachusetts, and New Hampshire were separated from the Boston MSA. The total reduction in payment attributable to the change in labor markets losses for inpatient reimbursement are estimated at more than **$1,200,000 per year** for Salem, New Hampshire based Northeast Rehabilitation Hospital alone.

Northeast Rehabilitation Hospital Projected Impact FY 2006

Northeast Rehabilitation Hospital is located literally on the border of Massachusetts and New Hampshire. It competes in the same labor market as its Massachusetts, Rhode Island and Vermont counterparts. These other areas currently have positive Medicare margins and will see their overall margins stay the same or rise as a result of the proposed revisions to the geographic classification. Conversely the proposed changes in geographic classification will result in a reduction of the Medicare Base Reimbursement Rate for Northeast Rehabilitation Hospital by approximately eight (8%) percent. See Table 13 below.

Per Table 13: Projected Impact of FY 2006 Proposed Refinements on Base Rate

		Total % Change
ALL IRFs	1,188	+2.9%
New England Urban IRFs	35	-0.1%
Northeast Rehabilitation Hospital		-7.7%

Additionally, as a result of these proposed changes, Northeast Rehabilitation Hospital will be one of only eight rehabilitation facilities in the country to experience a wage index reduction of greater than 10%. See Table 15 below.

Per Table 15: Impact of the Proposed FY 2006 CBSA - Based Area Wage Index :

PERCENTAGE of Facilities with a **wage index** DECREASE of more than 10%	**0.7%**
Total Inpatient Rehabilitation Facilities (IRFs)	**1,188**
IRF's with a wage index decrease greater than 10%	**8**

In Summary, although CMS states that the overall impact of these changes will be an increase of 2.9% in the base rate to IRFs, Northeast will experience a DECREASE of 7.7% in our Adjusted Federal Prospective Payment Rate and is **one of only eight facilities nationally** that will have a **DECREASE** in wage index **of greater than 10%.**

Based on the above fact pattern, Northeast Rehabilitation Hospital is requesting relief through the following changes in the proposed rule:

Recommendation for Final Rule

In view of the magnitude of this change and the disparity with our neighboring labor markets, we request that CMS provide relief in one or more of the following areas:

1. If a majority of the acute hospitals in the CBSA or county receive adjustments through the provisions included in the Acute PPS rules, the specialty hospitals in that same area will receive similar relief.
2. Allow IRFs to reclassify to another geographic area as allowed by the acute care hospitals rules.

3. Use a blended rate and allow a three year transition.
4. Include a hold harmless provision that limits the decrease to 3-4%.

Thank you for your consideration of our comments and request for relief. We would like to meet with agency staff to discuss this issue.

Sincerely,

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